001

From: 03/09/2017 03:24 #776 P.00

CORNERSTONE
Medical Center
100 Gross Crescent Circle, Fort Oglethorpe, Georgia 30742

MRSA:
VRE:
Advance Directive:

REGISTRATION ADMISSION

PATIENT ACCOUNT NO.: 0187729
MEDICAL RECORD N: 000684568

PATIENT (Name, Address, Phone)	BIRTH DATE	AGE	SEX	RACE	REL	SOCIAL SECURITY NO.	PRIMARY LAN
KOGER PHILLIP WAYNE JR	1984	32	M	W	N		E

MAR. STATUS	ETHNICITY	HO	ADMITTED BY	HIPAA
S	N	11	LAM	

RINGGOLD GA 307367908
COUNTY: CATOOSA
PHONE: (706)218-1663

ADMISSION DATE & TIME	DISCHARGE DATE & TIME	SERVICE	ROOM/BED
03/09/17 01:38		EMR	/

PATIENT EMPLOYER (Name, Address, Phone, Occ)	EMERGENCY CONTACT 1 (Name, Address, Phone, Rel)	EMERGENCY CONTACT 2 (Name, Address, Phone)
GAYLOR ELECTRIC PHONE: OCC:	KOGER RUTH ROSSVILLE GA 30741 PHONE: (706)858-7909 REL: GRANDSON OR GRANDDAU	PHONE: REL:

GUARANTOR	GUARANTOR EMPLOYER	ATTENDING PHYSICIAN (Name, Number)
KOGER PHILLIP WAYNE JR RINGGOLD GA 307367908 PHONE: (706)218-1663 REL: SELF	PHONE:	PRESTON MICHAEL 62

ADMITTING PHYSICIAN (Name, Number): PRESTON MICHAEL 62

REFERRING PHYSICIAN (Name, Number): 0

PRIMARY CARE PHYSICIAN (Name, Number): 0

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
PHONE: POLICY#: GROUP #: AUTH#: DOB: REL:	PHONE: POLICY#: GROUP #: AUTH#: DOB: REL:	PHONE: POLICY#: GROUP #: AUTH#: DOB: REL:

CHIEF COMPLAINT/ADMITTING DIAGNOSIS

COMMENTS

03/09/17 03:10

HM10000

filing fees, court costs, process service fees, alias summons and costs associated with post judgment proceedings including but not limited to pos[illegible] est and garnishment and execution fees. If my account is turned over to a collection agency I agree to pay the costs of collection in addition to the balance[illegible]

I assign to Erlanger Health System all benefits due me for treatment and/or hospitalization under an applicable policy of insurance. I understand that [illegible] System will file the initial health insurance claim for services provided as a courtesy and that it is my responsibility to provide accurate and complete [illegible] e policy information including any specific requirements applicable to my policy. Failure to provide accurate information, misleading information or non-co[illegible] oviding necessary information to accurately process the claim will result in the patient being billed directly and being financially liable.

I understand that while Erlanger Health System will assist me in attempting to obtain payment from my health plan by providing bill and other i[illegible] ested by the plan, I am financially responsible for payment for services rendered by Erlanger Health System.

- I have received a written copy of my patient bill of rights and notice of privacy practices. ☐ Yes ☐ No
  (For Medicare Patient) In the event I am admitted to the Hospital, I will be provided with a copy of the "Important Letter to Medicare Patie[illegible]
- I have received a copy of the Plain Language Summary of Erlanger's Financial Assistance Policy, and I have been verbally advised about Erlan[illegible] Assistance Policy. ☐ Yes ☐ No
- I consent to my name being listed in the Hospital directory for this visit. ☐ Yes ☐ No
  A choice of No means the Hospital information desk will not acknowledge your presence as a patient, except as required by law, to anyone wishing to [illegible] addition, all flowers will be returned to the florist, undeliverable.
- I consent to my name being provided to clergy. ☐ Yes ☐ No

7. Weapons/Explosives/Drugs

I understand and agree that if the Hospital at any time believes there may be a weapon, explosive devices, illegal substance or drug, or any alcohol[illegible] y room or with my belongings, the Hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them a[illegible] cluding delivery of any item to law enforcement authorities.

8. Social Security and Other Benefits

I have applied, or intend to apply, for benefits under all Titles of the Social Security Act for which I may be eligible (e.g., Titles II, XVI, XVIII, XIX)[illegible] y other benefits that may be available to me.

9. Appointment of Authorized Representative

I appoint the Hospital to act as my Authorized Representative in connection with my claim and/or other asserted right under my health benef[illegible] rize the Hospital to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my app[illegible] y stead. I understand that personal medical information related to my appeal may be disclosed to the authorized representative per my signature below. I al[illegible] rize the Hospital to act as my agent in order to obtain any authorizations and/or precertifications that may be required under my health benefit plan.

10. Elopement

By signing this form I acknowledge that, if I leave the patient care setting for more than two (2) hours, regardless of whether it is authorized by the Hos[illegible] rsonnel or medical team, and after a reasonable search you are unable to locate me, my departure shall be considered an elopement. The Hospital, its staff, [illegible] medical team will consider my elopement to mean I have discharged myself against medical advice, and my patient room shall be considered available for o[illegible] need of admission. The patient care setting shall include any area inside or outside that is on Hospital property. The patient care setting shall include all a[illegible] Iospital building. If I should return after having been gone more than two (2) hours I will be sent to the Emergency Room and treated as a new patient.

11. Education & Research

I understand and agree that the Hospital participates in educational and research activities. Unless required/permitted by law or for the internal us[illegible] al, it is the policy of the Hospital to obtain the approval of its Administration before agreeing to any external request, disclosure or use of any de-identified h[illegible] n from any person or entity who is not a health care professional, in training for or student of a health care profession/career or an instructor in a health care [illegible] itution. When the person or entity is not a health care professional, in training for or student of a health care profession/career or an instructor in a health care [illegible] itution, the Hospital Administration agrees to obtain written authorization from me or my authorized representative, but only if the Administration de[illegible] ization necessary to preserve my dignity. Any medical information used or disclosed outside of the Hospital for the education and training of health care [illegible] cluding students, residents, and instructors (such as presenting a case-study required by their health care profession educational institution), must be de-i[illegible] ould be presented with my dignity in mind, even if I become incapacitated or deceased.

I hereby certify and state that I have read, and that I fully and completely understand this Conditions of Admission and Authorization for Medic[illegible] d that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily. I also hereby certify that all o[illegible] n I have provided on this form is true and correct. I hereby represent that I have legal authority to give consent for the treatment of my minor child or the mino[illegible] ustody, and the consent of no other person is required by agreement, court order or otherwise for such treatment. Moreover, I certify and state that I hav[illegible] omises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. I understand that I am personally [illegible] ayment for any and all items or services not covered by insurance or other third party.

Recurring Accounts Only: Effective Dates ____________ to ____________

Patient's Initials ____________

Pt UTA — 3/9/17
Patient Signature — Date — Patient's Representative, if Patient is Unable to Sign/Rele[illegible] ent*

[signature] — 3/9/17
Witness (to Signature Only) — Date — *Address (Street, City, Zip)

2nd Witness Required with Verbal Authorization — Date

CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT

erlanger — Page 2 of 2 — 25131 (Rev. 11/08/16)

PATIENT IDENTIFICATION

KOGER ,PHILLIP WAYNE
01171273
000120-246-350
1984
M 32 Y
ADM: 03/09/17
EMCARE, PHYSICIA

003

Legal Relationship Between Hospital and Physician

I am under the care and supervision of my attending physician and it is the responsibility of the Hospital and its staff to carry out the instructions of my physician. It is my physician's responsibility to obtain my informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to me under general and special instructions of my physician. I **understand that there will be a separate charge for professional services, such as physician services. I understand that the Hospital does bill for some professional fees; otherwise, the professional fees will not be included in the Hospital's bill and I will receive a separate bill. My physician may or may not be an employee of the Hospital, and the Hospital is not responsible for the acts or omissions of any physicians not employed by the Hospital.**

1. Consent for Emergency Treatment

I believe that I am suffering from an emergency medical condition. I know this condition entitles me to an appropriate medical screening and treatment necessary to stabilize my condition under applicable state and federal law. I therefore authorize the Hospital to provide an appropriate medical screening evaluation and treatment, to be performed by or under the supervision of a physician or his/her aide. It has been explained to me the diagnostic and treatment procedure to which my emergency medical condition legally entitles me is limited and will include a medical screening examination in compliance with applicable state and federal law. It may be necessary for me to select another physician and obtain from him/her a complete diagnosis of my condition and such continued treatment as he/she may prescribe.

NOT APPLICABLE_____ CONSENT_____ REFUSE_____ *(Initial One)*

2. Consent to Medical and Surgical Procedures

I, the undersigned, consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, xray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me under the general and special instructions of my physician. This consent includes testing for blood-borne infectious diseases, including but not limited to hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), if a physician orders such test(s) for diagnostic purposes.

Please initial: Agree_____ Disagree_____ **to blood-borne infectious disease testing.**

I understand and acknowledge that the Hospital utilizes video monitoring for security purposes as well as for the diagnosis, care and treatment of patients and that such video monitoring occurs in both public and non-public areas of the Hospital to include direct care areas and patient rooms. By signing below, I understand, acknowledge and agree that I have no expectation of privacy in such areas of the Hospital and that the Hospital is not, in any way, liable as to any demands, causes of actions and suits, including but not limited to claims for invasion of privacy, unreasonable search and seizure, defamation, breach of contract or any other breach of duty arising out of or in connection with such video monitoring.

3. Assignment of Benefits

This assignment of benefits allows the Hospital and/or hospital-based physician(s) to be paid directly by my health insurance carrier or other health benefit plan for the services the Hospital and/or hospital-based physician(s) provides to me, my minor child, or other person entitled to health care benefits for this admission. In return for the services rendered and to be rendered by the Hospital and/or hospital-based physician(s), I hereby irrevocably assign and transfer to the Hospital and/or hospital-based physician(s) all rights, title, and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the Hospital and/or hospital-based physician(s) an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the Hospital and/or hospital-based physician(s) to pursue any such right of recovery. In no event will the Hospital and/or hospital-based physician(s) retain benefits in excess of the amount owed to the Hospital and/or hospital-based physician(s) for the care and treatment rendered during this admission. I understand that I may receive treatment from hospital-based physicians who do not have a current contract with my insurer (sometimes called "nonparticipating" physicians) and that I may receive a separate bill from such physician(s) for the amount not paid by my insurer. I certify that the insurance information I have provided to the Hospital is accurate in every respect and, as such, I hereby agree to be and remain financially responsible for any and all charges relating to the services provided in the instance that such insurance information I provided is not accurate.

4. Medicare Patient Certification

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf. I understand that self-administered medications are not covered by Medicare and that I will be responsible for payment of charges relating to all self-administered medications.

5. Personal Valuables

I accept full responsibility for any personal articles that I take to my bedside or treatment area. I understand that the Hospital maintains a safe for the safekeeping of money and valuables, and the Hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value and small size, unless placed therein; and shall not be liable for loss or damage to any other personal property, unless deposited with the Hospital for safekeeping.

6. Acknowledgements of Financial Responsibility

In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the account of the Hospital in accordance with the Hospital's Charge Master and terms of the Hospital. In the event any overpayment is received by the Hospital for this period of hospitalization, the undersigned authorize(s) application of the overpayment to any unpaid balance for which patient is responsible.

I agree to pay Erlanger Health System for any and all services rendered and expenses incurred by the patient. I, as the responsible person on this account, understand that bills are payable in full upon rendering of treatment. Bills for inpatient services are payable at discharge from the hospital.

I hereby consent and instruct that the Hospital can obtain my credit report at its sole discretion at any time and at its own expense and that the hospital may only provide such report to a third party for the sole purpose of aiding in collection evaluation and efforts on behalf of the Hospital. If my account is not paid in full within 30 days of the initial bill being sent to the last address I provided the Hospital and the Hospital has not confirmed in writing that Hospital has agreed to an acceptable payment plan, my account may be turned over for collection at Hospital's oprion. If my account is turned over to an attorney for collection, I agree to pay 33 1/3% of the balance for attorneys' fees regardless of whether filing a lawsuit is necessary to collect the balance. In addition to paying all costs incurred in filing the suit including but not limited to

Additional sections on back are incorporated by reference herein.

CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT

erlanger

CA8700

DATE

KOGER ,PHILLIP WAYNE
01171273 000120-246-350
11984 M 32 Y
ADM: 03/09/17
EMCARE, PHYSICIA

004

******AUTO**MIXED AADC 300
842 2 MB 0.423 000842
THE STANFORD LAW FIRM PLLC
909 HILLSBORO BLVD
MANCHESTER, TN 37355-2025 6pgs

00060000842K0/

ATTENTION

Confidential Information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested, please call the phone number on the enclosed invoice.

This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR §§ 2.12(c)(5) and 2.65.

If the enclosed record pertains to HIV/AIDS, it has been disclosed to you from records whose confidentiality is protected by federal and, perhaps, state law, which prohibits you from making any further disclosure of such information without the specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for this release of health or other information is not sufficient for this purpose.

This is confidential and privileged information. If it contains mental health information, it is for professional use only.

185646288

004

A ERLANGER MEDICAL CENTER
P. O. BOX 670
CHATTANOOGA, TN 37401
423 / 778-5150
FET # 62-6000101

PAGE NO. 1

HOSP.NO. 152702

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	03/14/17	
OUTP.		

S	E	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
		KOGER , PHILLIP WAYNE	120246350	M	32	03/09/17		

GUAR PH: (706)218-1663

GUARANTOR NAME AND ADDRESS
PHILLIP WAYNE KOGER
RINGGOLD GA 30736

S.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	SELF PAY		

SMITH, BENJAMIN C III MD

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS							
03/09/17	32076879 001 BCOSTRIX SYR 0.5 ML		74.00					74.00
03/09/17	34900860 100 OMNIPAQUE 300 50 ML		500.00					500.00
03/09/17	36501088 001 HCT ISTAT		72.00					72.00
03/09/17	36501146 001 BASIC METABOLIC PANEL		245.00					245.00
03/09/17	34100099 001 CHEST,AP/PA		254.00					254.00
03/09/17	34100479 001 PELVIS 1 OR 2 VIEWS		314.00					314.00
03/09/17	34101246 001 KNEE,3 VIEWS		319.00					319.00
03/09/17	34103416 001 HIP UNI 2-3 VWS W/ AP		200.00					200.00
03/09/17	34900308 001 THORAX,CT,W/CONTRAST		2603.00					2603.00
03/09/17	34905240 001 CT ABD PELVIS W CONTR		4290.00					4290.00
03/09/17	36000115 001 BLOOD GAS SAMPLING AR		89.00					89.00
03/09/17	36501005 001 BLOOD GAS ANALYSIS		175.00					175.00
03/09/17	26500066 001 TRAUMA ACTVTN III W/		6325.00					6325.00
03/09/17	53062717 001 HYDRATN INFUSN INIT 3		372.00					372.00
03/09/17	53062725 001 HYDRATN INFUSN EA ADD		209.00					209.00
03/09/17	53063616 001 EMERGENCY CARE IV-INT		1454.00					1454.00
	BALANCE FORWARD		0.00					

PATIENT NUMBER

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

A

ERLANGER MEDICAL CENTER
P. O. BOX 670
CHATTANOOGA, TN 37401
423 778-5150
FEI # 62-6000101

PAGE NO. 2

HOSP.NO. 152702

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	03/14/17	
OUTP.		

S	E	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
		KOGER ,PHILLIP WAYNE	120246350	M	32	03/09/17		

GUAR PH: (706)218-1663

GUARANTOR NAME AND ADDRESS

PHILLIP WAYNE KOGER

RINGGOLD GA 30736

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	SELF PAY		

SMITH, BENJAMIN C III MD

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	SUMMARY OF CURRENT CHARGES							
	PHARMACY		574.00					574.00
	LAB		317.00					317.00
	RADIOLOGY		1087.00					1087.00
	CT SCAN		6893.00					6893.00
	RESP. THERAPY		264.00					264.00
	EMERGENCY ROOM		8360.00					8360.00
	SUB-TOTAL OF CURR. CHARGES		17495.00					17495.00

GUAR RELATIONSHIP: S SEX: M GUAR NO: 258521000
ACC DATE: 03/09/17 TYPE: A TIME: 1:30 AM PLACE: 1 EMPL REL: N

TOTALS			17495.00					17495.00

PATIENT NUMBER 120246350

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PAY THIS AMOUNT 17495.00

ERLANGER MEDICAL CENTER
CHATTANOOGA, TN

006

007

*******AUTO**MIXED ADC 300
416 7 MB 2.010 000416
THE STANFORD LAW FIRM PLLC
CHRISTOPHER R STANFORD
909 HILLSBORO BLVD
MANCHESTER, TN 37355-2025

40pgs

00400004161K0Z

ATTENTION

Confidential Information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested, please call the phone number on the enclosed invoice.

This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR §§ 2.12(c)(5) and 2.65.

If the enclosed record pertains to HIV/AIDS, it has been disclosed to you from records whose confidentiality is protected by federal and, perhaps, state law, which prohibits you from making any further disclosure of such information without the specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for this release of health or other information is not sufficient for this purpose.

This is confidential and privileged information. If it contains mental health information, it is for professional use only.

185624724

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008 RECEIVED 10/18/2017 11:32
Oct. 18. 2017 10:34AM No. 5202 P. 2

THE STANFORD LAW FIRM, PLLC

909 HILLSBORO BOULEVARD
MANCHESTER, TENNESSEE 37355
www.stanfordmlaw.com

CHRISTOPHER R. STANFORD
CHRISTINA S. STANFORD

TELEPHONE: (931) 954-5577
FACSIMILE: (931) 954-5599

5/8

Wednesday, October 18, 2017

Via Facsimile

Erlanger Baroness Campus
975 East 3rd Street
Chattanooga, TN 37403
423-778-4157

Re: Phillip Wayne Koger
D.O.B. 1984

PT

To Whom It May Concern:

Enclosed with this letter you will find a medical records release for a patient, Phillip Wayne Koger, who was seen at your facility during March 9-10, 2017. Please forward all medical records and billing statements on file for Mr. Koger along with an invoice reflecting the costs of reproduction to our office at your earliest convenience. If prepayment for record reproduction is required please contact our office and indicate the same as soon as possible.

Thank you for your assistance with this matter and please do not hesitate to contact me with questions or comments.

Very truly yours,

THE STANFORD LAW FIRM, PLLC

By: Christopher R. Stanford /by ecd
Christopher R. Stanford

117273
3/09/17

170052040

RECEIVED OCT 25 2017
008

CORNERSTONE

Medical Center

100 Gross Crescent Circle, Fort Oglethorpe, Georgia 30742

MRSA:
VRE:
Advance Directive: N

PATIENT ACCOUNT NO: 0187729

REGISTRATION ADMISSION

MEDICAL RECORD NO: 000684568

PATIENT (Name, Address, Phone)	BIRTH DATE	AGE	SEX	RACE	REL	SOCIAL SECURITY NO	PRIMARY LANGUAGE
KOGER PHILLIP WAYNE JR	1984	32	M	W	N		E

MAR STATUS	ETHNICITY	FC	ADMITTED BY	HIPAA			
S	N	04	RPN	N	N	N	N

RINGGOLD GA 307367908
COUNTY: CATOOSA
PHONE: (706)218-1663

ADMISSION DATE & TIME	DISCHARGE DATE & TIME	SERVICE	ROOM / BED NO
03/09/17 00:24	03/09/17 07:13	EMR	/

PATIENT EMPLOYER (Name, Address, Phone, Occ)	EMERGENCY CONTACT 1 (Name, Address, Phone, Rel)	EMERGENCY CONTACT 2 (Name, Address, Phone, Rel)
UNEMPLOYED PHONE: OCC:	KOGER RUTH ROSSVILLE GA 30741 PHONE: (706)858-7909 REL: GRANDFATHER OR GRAND	PHONE: REL:

GUARANTOR (Name, Address, Phone, Rel)	GUARANTOR EMPLOYER (Name, Address, Phone)	ATTENDING PHYSICIAN (Name, Number)
POLICE DEPT CITY FT OGLET 900 CITY HALL DRIVE FORT OGLETHORPE GA 30742 PHONE: (800)532-7706 REL: OTHER RELATIONSHIP	PHONE:	PRESTON MICHAEL 623 ADMITTING PHYSICIAN (Name, Number) PRESTON MICHAEL 623 REFERRING PHYSICIAN (Name, Number) 0 PRIMARY CARE PHYSICIAN (Name, Number) NONE 0

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
FORT OGLETHORPE POLICE 500 CITY HALL DRIVE FORT OGLETHORPE GA 307420000 PHONE: (706)866-2512 POLICY#: 258551000 GROUP #: AUTH#: KOGER PHILLIP WAYNE JR DOB: 1984 REL: SELF	PHONE: POLICY#: GROUP #: AUTH#: DOB: REL:	PHONE: POLICY#: GROUP #: AUTH#: DOB: REL:

CHIEF COMPLAINT/ADMITTING DIAGNOSIS
ACUTE PAIN DUE TO TRAUMA G8911

COMMENTS
NO ID AVAILABLE

10/24/17 17:14

HM1000/022114

** 00010187729 HM1000 ADMISSIONS 03/09/17 000684568 KOGER PHILLIP WAYNE JR

Nurse's Notes
Emergency Department ofHutcheson Medical Center
Name:Phillip Koger Jr
Age:32 years
Sex:Male
DOB: /1984
MRN:684568
Arrival Date:03/09/2017
Time:00:24
Account#:187729
Bed9
Private MD:
Diagnosis:Closed Head Trauma, non-focal exam;Multiple Facial fractures;Left testicular trauma;Facial Laceration

Presentation:
03/09
01:00 Presenting complaint: law enforcement states he was in a high speed chase, cjw
unrestrained, broken windshield, and broke side window with his head. . Transition of
care: patient was not received from another setting of care. Care prior to arrival:
None.
01:00 Method Of Arrival: Police: Fort Oglethorpe cjw
01:00 Acuity: 3-Urgent cjw

Triage Assessment:
01:03 General: Appears uncomfortable, Behavior is crying. Pain: Complains of pain in chest, cjw
pelvis, right arm, left arm, posterior chest, back of left leg, back of right leg, back, face and scalp. Pain currently is 10 out of 10 on a pain scale.

Historical:
- Allergies:
01:02 No known drug Allergies; cjw
- Home Meds:
01:02 None; cjw
- PMHx:
01:02 fractured bones in mvc; cjw
- PSHx:
01:02 right leg; cjw

- Received names of patients medications from: : verbally from patient.
- Immunization history: Last tetanus immunization: unknown.

010

- Social history: Smoking status: Patient uses tobacco products, smokes one pack cigarettes per day. Patient uses alcohol street drugs, methamphetamine, marijuana.
- Private Physician:: No PCP.
- : Abuse screen: Denies threats or abuse. No signs of abuse noted. Fall Risk: None identified. Tuberculosis screening: No symptoms or risk factors identified. No recent
travel per patient.

Screening:
01:06 Nutritional screening: No deficits noted. cjw

Assessment:
01:04 Neuro: Level of Consciousness is awake, alert, Oriented to person, place, time, event. cjw
General: Appears distressed, uncomfortable, Behavior is crying. EENT: Nares with
bleeding noted. Cardiovascular: Capillary refill < 3 seconds. Respiratory: Airway is
patent. Respiratory effort is even, unlabored. Derm: Skin is normal, Bruising that is
bright red, on back and chest. Pain: Complains of pain in scalp and face and back and
back of right leg and back of left leg and posterior chest and left arm and right arm
and pelvis and chest. Pain currently is 10 out of 10 on a pain scale. GI: Abdomen is
flat, non- distended. GU: Reports pain testicle. Injury Description: Laceration sustained to face, is 2.6 to 7.5 cm long, is bleeding moderately.

Vital Signs:
00:50 BP 107 / 92; Pulse 108; Resp 20; Temp 98; Pulse Ox 91% on R/A; Weight 90.72 kg; Height cjw
6 ft. 2 in. (188 cm); Pain 10/10;
01:08 BP 103 / 84; Pulse 94; Resp 20; Pulse Ox 95% on R/A; Pain 10/10; cjw
06:22 BP 124 / 69; Pulse 89; Resp 16; Temp 98.2; Pulse Ox 95% on R/A; Pain 0/10; cjw
00:50 Body Mass Index 25.7 (90.72 kg, 188 cm) cjw

ED Course:
00:24 Patient arrived in ED. lm9
00:51 Preston, Michael, MD is Attending Physician. mp4
01:00 WOOD, JADE, RN is Primary Nurse. cjw
01:02 Triage completed. cjw
01:04 Pt educated on Speak-Up initiative. Patient states no special handling at this time. cjw

02:32 CT BRAIN W/O IVC Sent. rc6
02:32 CT CERVICAL SPINE W/O Sent. rc6
02:32 CT FACIAL W/O IVC Sent. rc6
02:32 SHOULDER RIGHT Sent. rc6
02:32 US TESTICULAR SCAN Sent. rc6
04:00 Assist provider with laceration repair on face that was between 2.6 to 7.5 cm using cjw
sutures. Set up tray. Performed by Michael Preston MD Patient tolerated well.
Dressings: assisted dr. preston with sutures to left cheek under eye. Wound care to
laceration located on face was irrigated with dressed with Patient tolerated well.
05:12 Inserted peripheral IV: 20 gauge in right antecubital area. cjw
07:11 Primary Nurse role handed off by WOOD, JADE, RN tk1
07:13 Patient has correct armband on for positive identification. Placed in gown. Bed in low cjw
position. Call light in reach. Side rails up X 1. Adult w/ patient.

Administered Medications:
05:11 Drug: Zosyn 3.375 grams; Route: IVPB; Site: right antecubital; cjw
05:38 Follow up: IV Status: Completed infusion cjw
05:56 Drug: morphine 4 mg; Route: IVP; Site: right antecubital; cjw
06:22 Follow up: Response: Pain is decreased cjw
05:57 Drug: Zofran 4 mg; Route: IVP; Site: right antecubital; cjw
06:22 Follow up: Response: Nausea is decreased cjw

Outcome:
03:38 ER care complete, transfer ordered by MD. mp4
06:23 Report called to renee, rn erlanger. cjw
07:12 Transferred to Erlanger Hospital Puckett EMS cjw
07:12 Condition: stable
07:12 Instructed on the need for transfer.
07:13 Patient left the ED. cjw

Signatures:
KREAKBAUM, TINA, RN RN tk1
Collins, Regina rc6
KEPLER, TREVOR, CMSS CMSS ttk
Preston, Michael, MD MD mp4
WOOD, JADE, RN RN cjw
Morgan, Leah lm9

****

Legally authenticated by PRESTON MICHAEL 2017-03-10 07:13:01

Physician Documentation
Hutcheson Medical Center
Name:Phillip Koger Jr
Age:32 years
Sex:Male
DOB: , , 1984
MRN:684568
Arrival Date:03/09/2017
Time:00:24
Account#:187729
Bed9
Private MD:
ED PhysicianPreston, Michael
HPI:
03/09
00:53 This 32 years old Male presents to ER via Police with complaints of MVC.
ttk
00:59 The patient was a driver of a car. pt was fleeing from police when he crashed the
ttk
vehicle. Per police, the pt was resisting arrest after the crash. Onset: The symptoms/episode began/occurred just prior to arrival. Associated injuries: The patient
sustained injury to the head, pain, laceration, abrasions, neck injury, upper back
injury, shoulders, left testicle. Associated signs and symptoms: Pertinent positives:
neck pain, diffuse pain, laceration below left eye, multiple abrasions, Loss of consciousness: no loss of consciousness. Severity of symptoms: in the emergency
department the symptoms a " 10" out of "10". Type of Encounter Initial Encounter. It is
unknown whether or not the patient has had similar symptoms in the past. It is unknown
whether or not the patient has recently seen a physician. 32 years old male presents to
the ED via police for evaluation after MVC. Police states the pt crashed his vehicle
after fleeing from police and resisted arrest after getting out of the vehicle. Pt was
not restrained with damage to the steering wheel. No damage to the windshield. Pt
reports neck pain, left testicle pain, left shoulder pain, body aches, laceration below
the left eye, multiple abrasions. Pt rates the pain as a 10/10 in severity. Pt has

dried blood in and around the nares, arms, chest, hands .

Historical:
- Allergies:
01:02 No known drug Allergies; cjw
- Home Meds:
01:02 None; cjw
- PMHx:
01:02 fractured bones in mvc; cjw
- PSHx:
01:02 right leg; cjw

- Received names of patients medications from: : verbally from patient.
- Immunization history: Last tetanus immunization: unknown.
- Social history: Smoking status: Patient uses tobacco products, smokes one pack cigarettes per day. Patient uses alcohol street drugs, methamphetamine, marijuana.
- Private Physician:: No PCP.
- : Abuse screen: Denies threats or abuse. No signs of abuse noted. Fall Risk: None identified. Tuberculosis screening: No symptoms or risk factors identified. No recent
travel per patient.

ROS:
00:55 Constitutional: Positive for body aches. ttk
00:55 Neck: Positive for pain with movement, pain at rest.
00:55 Back: Positive for pain at rest.
00:55 GU: Positive for left testicle pain.
00:55 Skin: Positive for abrasion(s), laceration(s), of the below the left eye.
00:55 All other systems are negative except as mentioned in HPI.

Exam:
01:03 Constitutional: The patient appears in no acute distress, alert, awake, well developed. ttk
01:03 Head/face: abrasions, 3 cm laceration below left eyelid.
01:03 Eyes: Pupils: equal, round, and reactive to light and accomodation, Extraocular movements: intact throughout.
01:03 ENT: Nose: dried blood in both nares.
01:03 Neck: ROM/movement: C-collar.
01:03 Cardiovascular: Rate: normal, Rhythm: regular.
01:03 Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, Breath sounds: are normal, clear throughout.
01:03 Back: ROM is painful.
01:03 Back: pain, no vertebral tenderness.
01:03 GU: left testicle tendernes.

01:03 Musculoskeletal/extremity: ROM: intact in all extremities, abrasions to left and right
knee.
01:03 Skin: Ecchymosis to back over left shoulder blade.
01:03 Neuro: Orientation: appropriate for stated age, to person, place & time. Mentation: is
normal, Motor: moves all fours.
01:03 Psych: Behavior/mood is pleasant, cooperative, Affect is calm.

Vital Signs:
00:50 BP 107 / 92; Pulse 108; Resp 20; Temp 98; Pulse Ox 91% on R/A; Weight 90.72 kg; Height cjw
6 ft. 2 in. (188 cm); Pain 10/10;
01:08 BP 103 / 84; Pulse 94; Resp 20; Pulse Ox 95% on R/A; Pain 10/10; cjw
06:22 BP 124 / 69; Pulse 89; Resp 16; Temp 98.2; Pulse Ox 95% on R/A; Pain 0/10; cjw
00:50 Body Mass Index 25.7 (90.72 kg, 188 cm) cjw

Laceration:
03:56 Wound Repair of 3cm (1.2in) subcutaneous laceration to face. Distal mp4
neuro/vascular/tendon intact. Anesthesia: Wound infiltrated with 5 mls of 1% lidocaine
w/ Epi. Skin closed with 3-0 Nylon using Running sutures. Dressed with 4x4's. Patient
tolerated well.

MDM:
01:03 Data reviewed: vital signs, nurses notes. ED course: Initial Exam: Plan of care ttk
discussed including x-ray and US to which the pt is agreeable.
01:03 ED course: Documentation prepared by Trevor Kepler, acting as medical scribe for Dr. ttk
Michael Preston, in accordance with hospital policy.
01:30 Patient medically screened. ttk
04:01 ED course: Cervical collar was removed by me when CT C-Spine report was received. mp4

03/09
01:06 Order name: CT BRAIN W/O IVC; Complete Time: 03:29 mp4
03/09
03:26 Interpretation: Left scalp hematoma; No acute intracranial finding per radiologist. mp4
03/09
01:06 Order name: CT CERVICAL SPINE W/O; Complete Time: 03:29
mp4

015

03/09
03:27 Interpretation: No acute fracture or dislocation per radiologist. mp4
03/09
01:06 Order name: CT FACIAL W/O IVC; Complete Time: 03:29 mp4
03/09
03:28 Interpretation: Multi facial fractures. mp4
03/09
01:06 Order name: SHOULDER RIGHT; Complete Time: 03:29 mp4
03/09
03:28 Interpretation: Non acute per radiologist. mp4
03/09
01:07 Order name: US TESTICULAR SCAN; Complete Time: 03:42 mp4
03/09
03:42 Interpretation: Decreased color flow to Left testicle, likely related to trauma..Patient is in danger of tersticular infarct. Repeat ultrasound recommended within 24 hours per radiologist. mp4
03/09
07:02 Order name: CT 3D RECON NOIMG EDMS
03/09
01:06 Order name: CERVICAL COLLAR; Complete Time: 01:06 mp4
03/09
02:46 Order name: SUTURE SET UP; Complete Time: 03:59 mp4
03/09
07:03 Order name: CT 3D RECON NOIMG EDMS

Dispensed Medications:
05:11 Drug: Zosyn 3.375 grams; Route: IVPB; Site: right antecubital; cjw
05:38 Follow up: IV Status: Completed infusion cjw
05:56 Drug: morphine 4 mg; Route: IVP; Site: right antecubital; cjw
06:22 Follow up: Response: Pain is decreased cjw
05:57 Drug: Zofran 4 mg; Route: IVP; Site: right antecubital; cjw
06:22 Follow up: Response: Nausea is decreased cjw

Disposition:
03:43 After interviewing the patient, I agree with HPI as documented. My personal exam mp4 reveals findings consistent with those documented. All diagnostic studies were reviewed and discussed. I confirm diagnosis as documented by the Scribe. After a review of the patient's case, we will initiate transfer to another facility, for higher level of care.

Disposition:

03/09/17 03:38 Transfer ordered to ERLANGER. Diagnosis are Closed Head Trauma, non-focal exam,
Multiple Facial fractures, Left testicular trauma, Facial Laceration.
- Reason for transfer: Higher level of care.
- Accepting physician is Dr. Paul Stout.
- Condition is Good.
- Problem is new.
- Symptoms are unchanged.

Signatures:

Dispatcher MedHost	EDMS
KEPLER, TREVOR, CMSS	CMSS ttk
Preston, Michael, MD	MD mp4
WOOD, JADE, RN	RN cjw

****

CORNERSTONE MEDICAL CENTER

DATE: 03/09/2017
FACILITY: Cornerstone Medical Center
PATIENT: KOGER, PHILLIP
SEX: Male
BIRTHDATE: [redacted] 1984
REFERRED BY: MICHAEL PRESTON
MEDICAL RECORD NUMBER: HMC7000137CT
ACCESSION NUMBER: RAM28995092

EXAM: CT Head w/o Contrast

CLINICAL INDICATIONS: MVA

FINDINGS:

TECHNIQUE:
Serial axial images of the head were obtained. Images were reformatted in coronal and sagittal planes and reviewed in brain, soft tissue and bone windows.

COMPARISON:
None.

FINDINGS:
There is no intra- or extra-axial fluid collection, mass effect, or midline shift. The gray-white matter junction is preserved. Normal attenuation is seen throughout the brain parenchyma.
Acute fractures of the left lacrimal bone, nasal spine, and anterior nasal septum. Polyps versus retention cysts in the right maxillary and right frontal sinuses. Mild mucoperiosteal thickening of left frontal, maxillary and sphenoid sinuses and left ethmoid air cells.Bilateral periorbital soft tissue hematoma, larger on the left.

IMPRESSION:
LEFT FRONTAL SCALP HEMATOMA. NO ACUTE INTRACRANIAL FINDING.

MULTIPLE FACIAL BONE FRACTURES.

All CT scans at this facility use dose modulation, iterative reconstruction, and/or weight based dosing when appropriate to reduce radiation dose to as low as reasonably achievable

Physician: Navid Zenooz, M.D. Signature: *Electronically Signed By* 3/9/2017 2:28 AM

Received: 3/9/2017 2:09 AM Read: 3/9/2017 2:28 AM (All Times Eastern)

CORNERSTONE MEDICAL CENTER

DATE: 03/09/2017
FACILITY: Cornerstone Medical Center
PATIENT: KOGER, PHILLIP
SEX: Male
BIRTHDATE: 1984
REFERRED BY: PRESTON
MEDICAL RECORD NUMBER: 030917PK84
ACCESSION NUMBER: RAM28995112

EXAM: US Testicular

CLINICAL INDICATIONS: Left testicular pain, MVA

FINDINGS:
US testicle
Clinical: Left testicular pain, MVA
Prior: None

Technique: Real-time gray scale and color-flow images were obtained of the scrotum and contents.

Findings:

Both testicles are descended.
Both testicles are slightly inhomogeneous along the inferior margins.
Right testicle measures 3.6 x 1.8 x 3.4 cm in size.
Left testicle measures 3.3 x 2.1 x 3.1 cm in size.
Decreased color flow to the left testicle.
Normal color-flow to the right testicle.
No solid intratesticular mass.
Left epididymis measures 0.5 x 1.36 cm in size.
Right epididymis measures 0.54 x 1.24 cm in size.

Note is made a small left-sided varicocele with Valsalva maneuver.

No scrotal wall thickening or fluid.

IMPRESSION:
1. DECREASED COLOR FLOW TO THE LEFT TESTICLE, LIKELY RELATED TO TRAUMA. PATIENT IS IN DANGER OF TESTICULAR INFARCT. RECOMMEND FOLLOW-UP TESTICLE ULTRASOUND WITHIN 24 HOURS TO REASSESS.

2. SMALL LEFT VARICOCELE.

This report was called to DR. PRESTON (Ph. 706-858-2160) at approximately 3/9/2017 3:35 AM.

Physician: Nicole Simpson, Signature: *Electronically Signed By* 3/9/2017 3:32 AM

Received: 3/9/2017 3:18 AM Read: 3/9/2017 3:32 AM (All Times Eastern)

CORNERSTONE MEDICAL CENTER

DATE: 03/09/2017
FACILITY: Cornerstone Medical Center
PATIENT: KOGER, PHILLIP
SEX: Male
BIRTHDATE: 1984
REFERRED BY: PRESTON
MEDICAL RECORD NUMBER: 090317_014257
ACCESSION NUMBER: RAM28995091

EXAM: XR RT SHOULDER

CLINICAL INDICATIONS: PAIN

Addendum
1. Y-view reviewed.No acute fracture or dislocation visualized.
(Qazi Uddin, 3/9/2017 2:55 AM)

2. Receipt of this report was verified by JAMES K. ER TECH (Ph. 706-858-2160) at approximately 3/9/2017 3:21:51 AM EST.
(Navid Zenooz, 3/9/2017 3:21 AM)

FINDINGS:
Technique: 2 views.

Comparison: None.

IMPRESSION:
NO DEFINITE ACUTE FRACTURE OR DISLOCATION IN THE RIGHT SHOULDER ON THESE 2 AP VIEWS; HOWEVER, A Y OR AXILLARY VIEW WAS NOT OBTAINED.

CLEAR VISUALIZED RIGHT LUNG.

Receipt of this report was verified by JAMES K. ER TECH (Ph. 706-858-2160) at approximately 3/9/2017 3:21 AM.

Physician: Navid Zenooz, M.D. Signature: *Electronically Signed By* 3/9/2017 2:09 AM

Received: 3/9/2017 2:07 AM Read: 3/9/2017 2:09 AM (All Times Eastern)

CORNERSTONE MEDICAL CENTER

DATE: 03/09/2017
FACILITY: Cornerstone Medical Center
PATIENT: KOGER, PHILLIP
SEX: Male
BIRTHDATE: 1984
REFERRED BY: PRESTON
MEDICAL RECORD NUMBER: 090317_014257
ACCESSION NUMBER: RAM28995091

EXAM: XR RT SHOULDER

CLINICAL INDICATIONS: PAIN

FINDINGS:
Technique: 2 views.

Comparison: None.

IMPRESSION:
NO DEFINITE ACUTE FRACTURE OR DISLOCATION IN THE RIGHT SHOULDER ON THESE 2 AP VIEWS; HOWEVER, A Y OR AXILLARY VIEW WAS NOT OBTAINED.

CLEAR VISUALIZED RIGHT LUNG.

Physician: Navid Zenooz, M.D. Signature: *Electronically Signed By* 3/9/2017 2:09 AM

Received: 3/9/2017 2:07 AM Read: 3/9/2017 2:09 AM (All Times Eastern)

Received: 3/9/2017 2:13 AM Read: 3/9/2017 2:28 AM (All Times Eastern)

Comerstone Medical Center PHILLIP KOGER 11/13/1984 HMC70001315CT RAM28995097
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www.cornerstonemedicalcenter.org

CORNERSTONE MEDICAL CENTER

DATE: 03/09/2017
FACILITY: Cornerstone Medical Center
PATIENT: KOGER, PHILLIP
SEX: Male
BIRTHDATE: 1984
REFERRED BY: PRESTON
MEDICAL RECORD NUMBER: 090317_014257
ACCESSION NUMBER: RAM28995091

EXAM: XR RT SHOULDER

CLINICAL INDICATIONS: PAIN

Addendum
1. Y-view reviewed.No acute fracture or dislocation visualized.
(Qazi Uddin, 3/9/2017 2:55 AM)

FINDINGS:
Technique: 2 views.

Comparison: None.

IMPRESSION:
NO DEFINITE ACUTE FRACTURE OR DISLOCATION IN THE RIGHT SHOULDER ON THESE 2 AP VIEWS; HOWEVER, A Y OR AXILLARY VIEW WAS NOT OBTAINED.

CLEAR VISUALIZED RIGHT LUNG.

Physician: Navid Zenooz, M.D. Signature: *Electronically Signed By* 3/9/2017 2:09 AM

Received: 3/9/2017 2:07 AM Read: 3/9/2017 2:09 AM (All Times Eastern)

CORNERSTONE MEDICAL CENTER

DATE: 03/09/2017
FACILITY: Cornerstone Medical Center
PATIENT: KOGER, PHILLIP
SEX: Male
BIRTHDATE: '1984
REFERRED BY: MICHAEL PRESTON
MEDICAL RECORD NUMBER: HMC7000139CT
ACCESSION NUMBER: RAM28995105

EXAM: CT C-Spine

CLINICAL INDICATIONS: MVA

FINDINGS:
EXAM: CERVICAL SPINE CT WITHOUT INTRAVENOUS CONTRAST

HISTORY: Neck pain.

TECHNIQUE: Thinmm spiral axial CT images are obtained through the cervical spine from the skull base to the thoracic inlet without the administration of contrast. Three-D reconstructed and 2-D sagittal and coronal reconstruction images are reformatted.
CTDI 15.72 mGy
DLP 414.48 mGycm

COMPARISON: None available.

FINDINGS:

There is no vertebral fracture seen. The atlantoaxial joint and odontoid process are intact.

There is no gross malalignment, spondylolisthesis, retrolisthesis, or perched facet joint seen.

Anterior endplate osteophytosis at C4/C5 level.

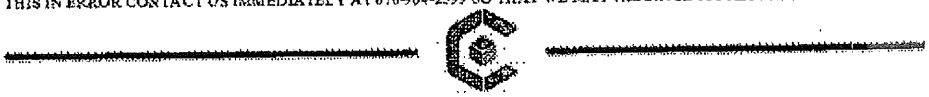
There is no gross disc herniation seen. Please note that subtle soft tissue abnormalities can be obscured in this radiographic setting. Consider follow-up MRI if clinically warranted.

IMPRESSION:
1. NO ACUTE FRACTURE OR DISLOCATION OF THE CERVICAL SPINE

All CT scans at this facility use dose modulation, iterative reconstruction, and/or weight based dosing when appropriate to reduce radiation dose to as low as reasonably achievable

Physician: Nicole Simpson, Signature: *Electronically Signed By* 3/9/2017 3:08 AM

Received: 3/9/2017 2:51 AM Read: 3/9/2017 3:08 AM (All Times Eastern)



www.cornerstonemedicalcenter.org

CORNERSTONE MEDICAL CENTER

DATE: 03/09/2017
FACILITY: Cornerstone Medical Center
PATIENT: KOGER, PHILLIP
SEX: Male
BIRTHDATE: 1984
REFERRED BY: MICHAEL PRESTON
MEDICAL RECORD NUMBER: HMC7000138CT
ACCESSION NUMBER: RAM28995097

EXAM: CT Facial w/o Contrast

CLINICAL INDICATIONS: MVA

FINDINGS:
COMPARISON:
None.

TECHNIQUE:
Serial axial images of the facial bones were obtained. The images were reformatted and reviewed in coronal and sagittal planes. Total DLP: [] mGy-cm CTDI vol: [] mGy

FINDINGS:

Acute fractures of the left lacrimal bone, nasal spine, and anterior nasal septum are noted. There are polyps versus retention cysts in the right maxillary and right frontal sinuses. Mild mucoperiosteal thickening of left frontal, maxillary and sphenoid sinuses and left ethmoid air cells is seen.

Bilateral periorbital soft tissue hematoma are noted, larger on the left.

Bilateral globes are intact.

The visualized airway is patent.

IMPRESSION:
MULTIPLE FACIAL BONE FRACTURES AS ABOVE.
All CT scans at this facility use dose modulation, iterative reconstruction, and/or weight based dosing when appropriate to reduce radiation dose to as low as reasonably achievable

Physician: Navid Zenooz, M.D. Signature: *Electronically Signed By* 3/9/2017 2:28 AM

FROM: TO:2688 03/09/2017 10:05:03 #279 P.001/001

From: 03/09/2017 03:29 #193 P.001/001

SCROTAL ULTRASOUND

PATIENT'S NAME: Koger, Phillip DATE: 3/9/17

ID (SS#): DOB: 84 AGE: 32

PHYSICIAN: Dr. Preston SONOGRAPHER: CA

CLINICAL HISTORY: Lt testicle pain i injury from MVA

STUDY TYPE (CPT): US Scrotal DIAGNOSIS (ICD-9):

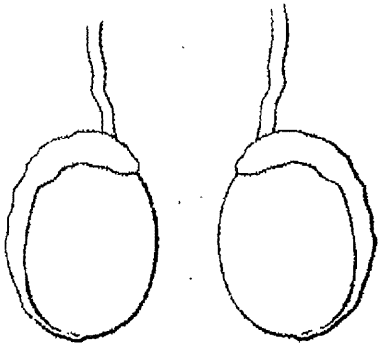
Palpable Lump ☒ No ☐ Yes-Location: Swelling ☐ Y ☒ N Pain ☒ Y ☐ N Trauma ☒ Y ☐ N

RIGHT

SIZE: 3.6 cm Length × 1.8 cm A-P × 3.4 cm Width

Echogenicity:

Vascularity:



LEFT

SIZE: 3.3 cm Length × 2.1 cm A-P × 3.1 cm Width

Echogenicity:

Vascularity: ↓ flow

RIGHT FINDINGS

Testis:
☐ WNL ☐ Orchitis ☐ Atrophy
☐ Hydrocele: ☐ Mild ☐ Moderate ☐ Large

Epididymis:
☐ WNL ☐ Epididymitis ☐ Not well visualized
☐ Hypervascular ☐ Hypovascular

Epididymal Head (if enlarged) 1.2 mm Length

Nodule #1: ☐ Cystic ☐ Solid ☐ Complex (Cystic & Solid)
Size ____ cm Length ____ cm AP ____ cm Width
Location

Nodule #2: ☐ Cystic ☐ Solid ☐ Complex (Cystic & Solid)
Size ____ cm Length ____ cm AP ____ cm Width
Location

Nodule #3: ☐ Cystic ☐ Solid ☐ Complex (Cystic & Solid)
Size ____ cm Length ____ cm AP ____ cm Width
Location

Other

LEFT FINDINGS

Testis:
☐ WNL ☐ Orchitis ☐ Atrophy
☒ Hydrocele: ☐ Mild ☐ Moderate ☐ Large

Epididymis:
☐ WNL ☒ Epididymitis ☐ Not well visualized
☐ Hypervascular ☐ Hypovascular

Epididymal Head (if enlarged) 1.4 mm Length

Nodule #1: ☐ Cystic ☐ Solid ☐ Complex (Cystic & Solid)
Size ____ cm Length ____ cm AP ____ cm Width
Location

Nodule #2: ☐ Cystic ☐ Solid ☐ Complex (Cystic & Solid)
Size ____ cm Length ____ cm AP ____ cm Width
Location

Nodule #3: ☐ Cystic ☐ Solid ☐ Complex (Cystic & Solid)
Size ____ cm Length ____ cm AP ____ cm Width
Location

Other

SONOGRAPHER IMPRESSION:

Hypoechoic area inferior to Lt testicle
pockets w/ heterogenous material floating w/in - located superior to Lt testicle
Possible varicoceles
↓ flow in Lt testicle

DEMAND BILL

CORNERSTONE MEDICAL CNTR
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA
30742-3643
706-858-2060

PATIENT NAME	ACCOUNT NO.	ADMIT DATE	DIS. DATE	PAGE
KOGER PHILLIP WAYNE JR	187729	3/09/17	3/09/17	1

508718 GUARANTOR NAME/ADDR.
POLICE DEPT CITY FT OGLET
900 CITY HALL DRIVE
FORT OGLETHORPE GA 30742

F/C 04
INS. CO/PLANS: FORT OGLETHORPE
POLICY #: 258551000

AGE: 32
DR. NAME: PRESTON MICHAEL

CHRG CODE	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
3/09/17 0063031	RD SHLDER MIN 2V RT	1	350.00	350.00	73030 RT
3/09/17 0066870	US TESTICULAR SCAN	1	761.00	761.00	76870
3/09/17 0060450	CT BRAIN W/O IVC	1	1515.00	1515.00	70450
3/09/17 0060486	CT FACIAL W/O IVC	1	1515.00	1515.00	70486
3/09/17 0062125	CT CERVICAL SPINE WO	1	1515.00	1515.00	72125
3/09/17 0066375	CT 3D RECON NO IMG	1	254.00	254.00	76376
3/09/17 0066375	CT 3D RECON NO IMG	1	254.00	254.00	76376
3/09/17 0071278	ONDANSETRON 4MG INJ	4	23.91	95.64	J2405
3/09/17 0071827	ZOSYN 3.375GM/D5W100	3	30.38	91.14	J2543
3/09/17 0072093	MS 5MG/1ML INJ	1	64.35	64.35	J2270
3/09/17 0230010	IV INF UP TO 90M	1	838.00	838.00	96365
3/09/17 0230016	EA + IV PUSH NEW SUB	2	230.00	460.00	96375 59
3/09/17 0232505	25 LVL V COMPREHEN	1	1926.00	1926.00	99285 25

** SUMMARY OF CHARGES **	
** TOTAL CHARGES **	9639.13
** TOTAL PAYMENTS **	.00
** TOTAL ADJUSTMENTS **	.00
** TOTAL AMOUNT DUE **	9639.13

PRIMARY DIAGNOSIS : S0990X UNSPECIFIED INJURY OF HEA

SIGNATURE : _____
TAX I.D. : 810838799
PROVIDER # : 110236

Ciox Health
P.O. Box 409740
Atlanta, Georgia 30384-9740
Fed Tax ID 58 - 2659941
1-800-367-1500

CIOX HEALTH

INVOICE

Invoice #: 0230045131
Date: 10/25/2017
Customer #: 2102751

Ship to:	Bill to:	Records from:
CHRISTOPHER S THE STANFORD LAW FIRM PLLC 909 HILLSBORO BLVD MANCHESTER, TN 37355-2025	CHRISTOPHER S THE STANFORD LAW FIRM PLLC 909 HILLSBORO BLVD MANCHESTER, TN 37355-2025	CORNERSTONE MEDICAL CENTER 100 GROSS CRESCENT CIRCLE FORT OGLETHORPE, GA 30742

Requested By: THE STANFORD LAW FIRM PLLC **DOB:** 111384
Patient Name: PHILIP W KOGER

Description	Quantity	Unit Price	Amount
Basic Fee			25.88
Retrieval Fee			0.00
Per Page Copy (Paper) 2	20	0.97	19.40
Per Page Copy (Paper) 1	1	0.83	0.83
Shipping			1.82
Subtotal			47.93
Sales Tax			4.67
Invoice Total			52.60
Balance Due			52.60

Pay your invoice online at https://paycioxhealth.com/pay/

Terms: Net 30 days

Please remit this amount : $ 52.60 (USD)

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P.O. Box 409740
Atlanta, Georgia 30384-9740
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Email questions to collections@cioxhealth.com.

* * * Communication Result Report (Oct. 18. 2017 10:36AM) * * *

1)
2)

Date/Time: Oct. 18. 2017 10:35AM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
5203	Memory TX	17068582044	P. 3	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

THE STANFORD LAW FIRM, PLLC
909 HILLSBORO BOULEVARD
MANCHESTER, TENNESSEE 37355

Fax

Wednesday, October 18, 2017

TO: CORNERSTONE MEDICAL	FROM: CHRIS R. STANFORD
	PAGES:
FAX 706-858-2044	FAX: 931.954.5599
PHONE:	PHONE: 931.954.5577

RE: PHILLIP WAYNE KOGER

Letter & Signed Medical Authorization

Thank You,
Karrissa McCormick

- ☐ Urgent
- ☐ Please review
- ☐ Please comment
- ☐ For your records

CORNERSTONE MEDICAL CENTER

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Contact Us

Home / Contact Us

If you or someone you know is experiencing a medical emergency, please call 911. If you have a question regarding an urgent matter, please call our hospital directly at 706-858-2000.

Telephone Directory

Main Number:
706-858-2000

Patient Billing Questions/Inquiries:
706-858-2000, ext. 7430

Emergency Room:
706-858-2161

Human Resources:
706-858-2140

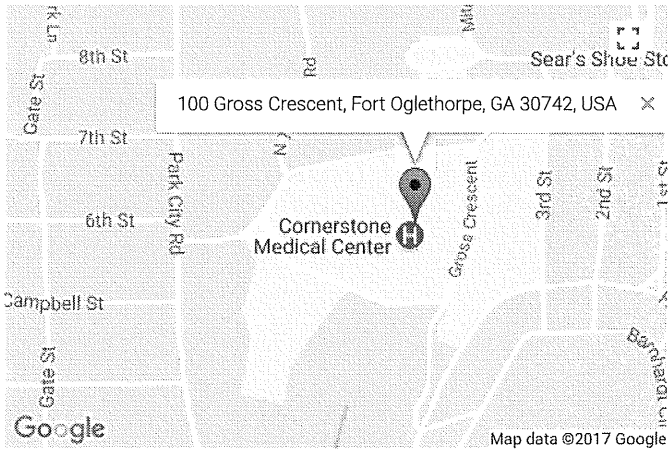
Lab Services:
706-858-4101

Pharmacy:
706-858-2280

Radiology:
706-858-7440

Grievance Hotline:
706-858-2105
patientvoice@cornerstonemedicalcenter.org

To contact a **patient room**, please dial 706-858-5 plus the room number.



100 Gross Crescent Circle
Fort Oglethorpe, Georgia 30742

********** ERLANGER HEALTH SYSTEM OUTPATIENT FORM **********
Pt No: 000120-246-350 Fac Cd: BEH ERLANGER Med Rec No: 0117-12-73
Pt Name: KOGER ,PHILLIP WAYNE Hosp Svc: BED Surg Case:
Nurs Sta: Room/Bed: FC: S PT Type:
CLINIC Cd1: BEER Clinic Cd2: Clinic Cd3: Clinic Cd4:
********** PATIENT INFORMATION **********
SSN: Birthdate: 1984 Marital Status: S Sex: M
706 218-1663

RINGGOLD GA 30736-
********** PATIENT EMPLOYER INFORMATION **********
GAYLOR ELECTRIC
UNKWN
N/A
00000-
Occupation: 000 - 000-0000 Ext
********** GUARANTOR INFORMATION **********
Guar Name: KOGER ,PHILLIP GUAR SSN: 258-52-1000

RINGGOLD GA 30736-
706 - 218-1663
********** ADDITIONAL CONTACT PERSONS **********
KOGER ,ANNETTE PT REL:
HOME PHONE: 706 - 965-6872 WORK PHONE: 706 - 965-6872 EXT:
KOGER ,RUTH PT REL:
HOME PHONE: 706 - 858-7909 WORK PHONE: - EXT:
****
Medicare Part A & B Coverage
INSURANCE TYPE: BENEFITS:
INSURANCE TYPE: BENEFITS:

********** INSURANCE INFORMATION **********
Ins Code: S01 SELF PAY Sub Rel: 01 COB: 1
Subscriber KOGER ,PHILLIP
Policy No: 258521000 Precert/Treat Auth:
PCP Refer/Auth: GA Better Health:

Ins Code: Sub Rel: COB:
Subscriber:
Policy No: Precert/Treat Auth:
PCP Refer/Auth: GA Better Health:

Ins Code: Sub Rel: COB:
Subscriber:
Policy No: Precert/Treat Auth:
PCP Refer/Auth: GA Better Health:

Ins Code: Sub Rel: COB:
Subscriber:
Policy No: Precert/Treat Auth:
PCP Refer/Auth: GA Better Health:

Reg DT/TM: 03/09/17 08:00 Reg Source: UA Method of Arr: 15
Reg Dr No 123331 Atn Dr Name: SMITH, BENJAMIN C II Atn Dr No: 123331
PCP Dr Name: PCP Dr No: Lst ED Vst: 03/09/17
Ad Dir Exec: N In Med Rec: N Pt Informed: N Entered By: KRS354
Complaint: FACIAL FX

Patient Information

Name: Phillip Koger
Race: White Ht: 6ft 2 Wt: 225 (Lbs) / Kg.

Trauma Activation Response

Trauma Pager Fire Time: 0754 Level: I II (III)
Initiated: PTA (On arrival to ER)
Date of Arrival: 3-9-17 Arrival Time: 0758 ED Bed: 8

	Names	Times
Trauma Attending		
Chief Resident		
Trauma NP		
ED Physician	Benson	0805
ED RN	Sarah	0758
CCNC	Tania, Emily	0758
Pharmacist		
Respiratory	Barry	0800
X-Ray	present	0805
Chaplain		
Other		

Prehospital

Injury Time: 2300
City / County of Incident: Walker
Description of Events: Transfer from cornerstone for facial fx. pt was in a high speed chase w/ police & crashed. pt was unrestrained. pt brought in initially by police to cornerstone.

Prehospital Medications: Morphine, Zofran, Zosyn
EMS#1: Fire & Rescue EMS#2: Pickett
B/P: 140/70 HR: 80 Temp: RR: 18 GCS: 15
SA02: 96 O2@ RA L via:
Referring Facility: cornerstone Referring MD:

Mechanism of Injury

MVC: ☐Single Vehicle ☐Auto vs.
☒Driver ☐Passenger:(position)
☐Restrained Y / N MPH: 70
☐Airbag Deployment: ☐Front ☐Side ☐N/A
☐Rollover ☐Ejected: ft ☐Extrication: min.
☒Damage: Steering Wheel / Windshield ☐Intrusion in.
MCC: ☐Motorcycle ☐ATV ☐Ejected: ft.
☐Helmet Y / N ☐Protective Clothing / Eyewear
Fall: ☐ Distance: ☐Surface:
Blunt: ☐Pedestrian vs. ☐Assault
☐Bicycle vs. ☐Other:
Penetrating: ☐GSW ☐Stabbing ☐Other:
Other MOI: ☐Burn ☐Machinery / Tool

Patient History

PMHX: Ø
PSHX: appy
Home Medication: Ø
Allergies: NKDA
Tetanus: <5yrs >5yrs UNK Last PO Intake:
LMP: Gravida: Para:

Assessment Upon Arrival

Airway / Breathing: ☒WNL ☐Distress: Mild Moderate Severe
☐Lung sounds CTAB ☐Decreased R / L ☐Wheezing ☐Crackles
Note:

Circulation: ☒Skin Warm & Dry ☐Cool ☐Pale ☐Diaphoretic
☐Cyanotic Capillary Refill: ☒<2 sec ☐>2 sec
☒Pulse WNL ☐Deficit
Note:

Neurological: Orientation: ☒Person ☒Place ☒Time ☒Event
☐Confused ☐Agitated ☐Unresponsive GCS: 15
Pupils: R Size 2 mm ☒Reactive ☐Sluggish ☐Non-reactive
L Size 2 mm ☒Reactive ☐Sluggish ☐Non-reactive
Sensation: ☒WNL ☐Numbness ☐Weakness
Note:

Head: ☐WNL Face: ☐WNL Note: Facial FX

Chest/Abdomen: ☒Chest WNL ☐Chest Trauma ☐Chest Pain
☒Abdomen WNL ☐Abd. Trauma ☐Abd. Pain ☐Bowel Sounds
☐Tenderness ☐Distention ☐Rigid ☐Nausea ☐Emesis
Note:

Pelvic/GU: ☐Pelvic WNL ☒Pelvic Pain ☒Genital Injury
☐Blood at Meatus Rectal Tone: Y / N Rectal Blood + / -

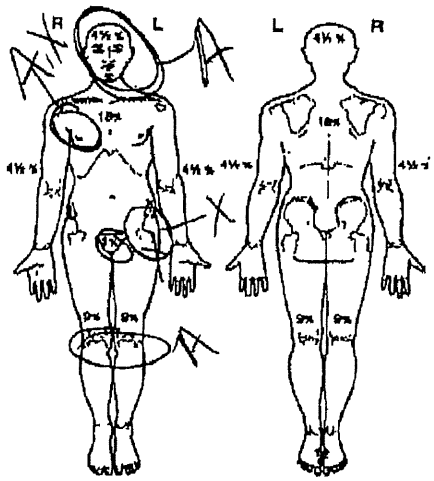
Extremities: ☒MAE ☐Limited ROM ☐RUE ☐LUE ☐RLE ☐LLE
Neurovascular ☒WNL ☐Compromised ☐Deformity to:
Note:

Neck/Back: ☒Neck WNL ☐C-Collar ☒Back WNL ☐Spine Board

RN Signature: S. Armstrong, RN

Mark area of injury
Legend

A	Abrasion
Amp	Amputation
Av	Avulsion
CP	Compound
C	Contusion
D	Deformity
EC	Ecchymosis
E	Edema
Fx	Fracture
H	Hematoma
L	Laceration
P	Pain
PT	Petechiae
R	Rash
SC	Scar
S	Swelling
X	Tenderness
STB	Stab Wound
GSW	Gunshot Wound
B1	1st Degree Burn
B2	2nd Degree Burn
B3	3rd Degree Burn
% burn	



Consults

Neurosurgery	Called @	Arrived @
Orthopedics	Called @	Arrived @
PRS	Called @	Arrived @
Other Urology	Called @	Arrived @

erlanger

Trauma Flowsheet

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HP0630

KOGER, PHILLIP WAYNE 000120-246-350
01171273
1984 M 32 Y
EMCARE, PHYSICIA ADM: 03/09/17

Time:	Procedures and Treatments
0758	☐All Quiet ☐Moved to Stretcher ☐Monitors Applied ☐Alarms Set/Functioning ☐ABC Intact
0758	**Oxygen Delivery:** ☑RA ☐NC @ ___L ☐NRB@ ___L ☐BVM ☐Nasal Airway ☐Oral Airway **Intubation:** ☐RSI ☐Oral ☐Nasal ☐Crich ETT#___mm Secured:___cm @ lip Placement: ☐CO2 Det ☐Auscultation ☐Film
0758	☐Pt Exposed ☑Warm Blankets Applied **EKG:** ☐ left ☐ Right Shown to Dr :
PTA	**IV Start:** 20 gauge location: R-AC ☑PTA ___ gauge location:___ ☐PTA ___ gauge location:___ ☐PTA ___ gauge location:___ ☐PTA
	Spineboard: DC'd @___ ☐ Logroll ☐Assist X ___ ☐ C-Collar Present on arrival ☐C-Collar placed at ___ ☐EMS Collar changed to Aspen at ___ ☐ Logrolled With C-Spine Immobilization Maintained
0805	**X Ray:** ☑Chest ☐Pelvis Other: hip, knee
0822	**Lab Draw:** Site: R-femoral Drawn by: Barry ☑Hemostasis Achieved ☑Labeled at Bedside Blood Labeled by: Zach ☑Sent to Lab
0837	**CT Scan:** ☐Head ☐Face ☐CSP ☑TSP ☐LSP ☐Chest ☑ABD ☑Pelvis Contrast (Y) / N Other:___ Transported with ☐ ED Tech ☑ RN ☐ MD Back From CT @ ___
	Laceration Repair: ☐Staples ☐Sutures Site:___ Performed By:___ Stop Time:___
	Ultrasound: ☐FAST + / - Performed By: ___ ☐Preg. ☐Other FHR:___ Gestation:___weeks
	G Tube: ☐NG R / L Nare ☐OG size: ___f Placement: ☐Auscultation ☐Aspiration Gastric Contents:___ Initial Output:___ml
	Ortho: ☐Splinting ☐Pin ☐Reduction ☐Washout Location: ___ Performed By: ___ ☐Refer to Mod. Sedation Flowsheet ☐Traction Weight Applied ___lb.
	Chest Tubes: ☐Right ___f ☐Left ___f ☐ATS Initial Output: Right:___ml Left:___ml ☐Thoracotomy ☐Needle Decompression R/L

Time:	Procedures and Treatments
	Arterial Line: ☐ PCI Kit ☐ Arrow ☐ 3 in. ☐ 6 in. ☐ 20g. ☐ 7f ☐ Other:___ Location:___ Placed By:___ Preparation:___ Analgesia/Anesth:___ ☐ Zeroed/Balanced ☐ Adeq WF Hematoma @ Site: Y / N ☐ See Procedure Sticker in Progress Notes
	Central Line: ☐ Trauma Line ☐ TLC ☐ QLC ☐ DL Power-Injectable ☐ Other ___ **Location:** ☐ Femoral L / R ☐ Subclavian L / R ☐ Internal Jugular L / R **Placed By:** ___ ☐ Followed Sterile Procedure ☐ Completed CLABSI Form ☐ F/U CXR ordered ☐ Occlusive DRSG Placed ☐ Central Line Verified For Use By ___ @___
	Foley Cath: Size:___f ☐Temp Foley Urine Color:___ Urine Clarity:___ Initial Output:___ ml ☐UA Collected/Sent to Lab ☐ Cath Secure Used
	Reboa Catheter: Placed By___ Time Inserted:___ Initial Volume Placed:___
	Hypo/Hyperthermia: ☐ Bair Hugger° ☐ Warm Blankets ☐ Warming Lights ☐ Blanketrol° (cooling blanket)
	Interventional Radiology: To IR @ ___ Transported with: ☐ RN ☐ CCNC ☐ MD ☐ Refer to Interventional Radiology Charting/Flowsheet

Intake/Output

Prehospital: Intake: ~~—~~ Output: ~~—~~

ED Intake		ED Output	
Crystalloid:	~~—~~	Urine:	250
Colloid:	~~—~~	NGT / OGT:	~~—~~
Blood:	~~—~~	Chest Tube Left:	~~—~~ Right: ~~—~~
Chest Tube ATS:	~~—~~	Other:	~~—~~
PO / Gastric:	~~—~~		

Disposition

Valuables: Items:___
☐All Valuables w/ Patient ☐Family:___ ☐Law Enforcement
☐ Secured
☐ PPS completed by Pt Care Rep. ___
Admission: To Unit/Floor___ @___
Via ☐Stretcher ☐W/C ☐Carried ☐Oxygen ☐Monitor ☐Vent
☐C-Collar: ☐Philly ☐Aspen
Escorted to unit/floor by: ☐Trauma team ☐RN ☐EDT ☐RT
Donor Service/Spoke with:___
Dismissal Time: 1215 @ ☑Discharged ☐AMA ☐Transfer ☐Death
Audit Tool Complete: (Y) / N Score: 0 MBP Fired Y / N
RN Signatures: S. Armstrong RN

Trauma Flowsheet

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HP0630

PATIENT IDENTIFICATION

KOGER, PHILLIP WAYNE
01171273 000120-246-350
984 M 32 Y
EMCARE, PHYSICIA ADM: 03/09/17

Time	Vital Signs: B/P	Source	HR	RR	Temp	Source	SAO2	O2 Delivery	Pain	Glasgow: E	V	M	Score	Initials
0800	136	87	NIBP	99	18	97.3	ORAL	98	RA	7	4	5	6	15	SA
0812	161	93	NIBP	105	17	—	—	99	RA	7	4	5	6	15	SA
0822	157	96	NIBP	115	9	—	—	98	RA	7	4	5	6	15	SA
0848	162	106	NIBP	89	12	—	—	98	RA	5	4	5	6	15	SA
0905	160	90	NIBP	105	20	—	—	90	RA	5	4	5	6	15	SA
1010	150	97	NIBP	98	17	—	—	96%	RA		4	5	6	15	CW

ED Critical Care Time: Start Time:_____ Stop Time:_____ Total Time (minutes):_____

Start Time	Stop Time	IV Bag #	Solution / Medication / Blood Product	Dose / Volume	Route / Site	Total Volume Infused	Indication / Notes / Response	Initials	Ordering Service
0825	1010	1	LR	1000mL	R-AC	1000mL	hydration	SA	ED

Ordering MD Signature: _____ RN Signature S. Armstrong, RN

Ordering MD Signature: _____ MD Signature _____

Level 1 Fluid Warmer / Rapid Infuser: Start:_____ Stop:_____

Trauma Flowsheet

erlanger Page 3 of 4 150407 1-16-2017

HP0630

PATIENT IDENTIFICATION

KOGER ,PHILLIP WAYNE
01171273 000120-246-350
M 32 Y
EMCARE, PHYSICIA ADM: 03/09/17

Time	Narrative
0158	pt arrives via puckett ems to ed bed 8. pt transferred from cornerstone med. center for facial fx. pt is not in spinal precautions upon arrival. ABC's are intact. SA
0837	pt transported to ct scan w/ RN SA
1115	Pt tolerating PO liquids. Pt requesting to call Mom to come pick him up. Pt ready for discharge.
1121	Pt given portable phone to call mom for ride.
1124	IV to right forearm removed, pt to be discharged
1129	Attempting to reach mother of pt at work at walmart #508-1157
1215	pt discharged to the lobby where mother was waiting. SA

/ S. Armstrong RN

Trauma Flowsheet

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HP0630

PATIENT ID
KOGER ,PHILLIP WAYNE
01171273 000120-246-350
1984 M 32 Y
EMCARE, PHYSICIA ADM: 03/09/17

BARONESS ERLANGER EMERGENCY DEPARTMENT EMERGENCY RECORD

Koger, Phillip Wayne
DOB: 1984 M32
Wt/Ht: 102.1 Kg 187 cm.
MedRec: 01171273
AcctNum: 120246350

Patient Data

Complaint: facial fractures
Triage Time: Thu Mar 09, 2017 07:58
Urgency: ESI Level 2
Bed: ED BEH-ED
Initial Vital Signs:
BP:
P:
O2 sat:
R:
T:
Pain:
ED Attending: Smith, MD, Benjamin
Primary RN: Armstrong, RN, Sarah E

TRIAGE (Thu Mar 09, 2017 07:58 AHUN)

TRIAGE NOTES: Patient presents to ED s/p mvc. pt was unrestrained driver of vehicle high speed chase from the police that lost control of the car. Pt transfer from Cornerstone for facial fractures., SEASON FLU/2013 NOVEL VIRUS/EBOLA SCREENING / Enterovirus D68: The patient does not have a sore throat, Temp is less than 100.0F, no cough, no sneezing, no rhinorrhea or nasal congestion, no dyspnea, no flul-like symptoms, The patient has NO recent travel outside the United States within the last 21 days., Taken directly to treatment room for triage or by EMS. (Thu Mar 09, 2017 07:58 AHUN)

COMPLAINT: facial fractures. (Thu Mar 09, 2017 07:58 AHUN)

MEASLES SCREEN: no rhinorrhea, Temp is less than 105.0F, no cough, no conjunctivitis, no rash, **A face mask was not applied to the patient.** (Thu Mar 09, 2017 08:54 SEAR)

PATIENT: AGE: 32, GENDER: male, DOB: [redacted]1984, PRE-HOSPITAL NOTIFICATION: Thu Mar 09, 2017 07:31, RACE: White, Not Hispanic, Holiday, Event, MCI: No, Travel outside US?: No recent travel outside the U.S., Isolation Precaution: Standard Precautions, Latex Allergy: No Latex Allergy, Patient Origin: Hutcheson Med Ctr – Ft Oglethorp GA, PCP/Special: None. Patient has, no PCP- See. (Thu Mar 09, 2017 07:58 AHUN)

NAME: Koger, Phillip Wayne. (Thu Mar 09, 2017 08:00)

KG WEIGHT: 102.1, HEIGHT: 187cm, BMI: 29.20. (Thu Mar09, 2017 08:54 SEAR)

KG WEIGHT: 102.1, HEIGHT: 187cm, BMI: 29.20. (Thu Mar09, 2017 08:54 SEAR)

TRIAGE INFORMATION: Pain level 6 Hurts Even More, using faces pain scoring. (Thu Mar 09, 2017 08:54 SEAR)

TREATMENTS IN PROGRESS: EMS/First Responder/By-stander care prior to arrival, Arrived via EMS, **Patient transferred from another facility**, Transferring facility: **cornerstone.** (Thu Mar09, 2017 08:54 SEAR)

SPECIAL NEEDS: No special needs identified, Do you communicate in a language other than English at home? NO, English is used., No accommodations are requested. (Thu Mar 09, 2017 08:54 SEAR)

ADMISSION: URGENCY: ESI Level 2, ADMISSION SOURCE: Ambulance – Puckett EMS, AMBULANCE: Puckett EMS, TRANSPORT: Stretcher, BED: BEH-ED 08. (Thu Mar 09, 2017 07:58 AHUN)

PROVIDERS: TRIAGE NURSE: Ashley L Hunzelman, RN. (Thu Mar 09, 2017 07:58 AHUN)

ESI ALGORITHM: ES level 2. (Thu Mar 09, 2017 08:54 SEAR)

PREVIOUS VISIT ALLERGIES: No Known Drug Allergies. (Thu Mar 09, 2017 08:54 SEAR)

AMBULANCE (Thu Mar 09, 2017 07:31 AHUN)

AMBULANCE: Ambulance: Thu Mar 09, 2017 07:31.

DIAGNOSIS (Thu Mar 09, 2017 10:24 BEN)

FINAL: PRIMARY: **facial fractures**, ADDITIONAL: **scrotal contusion, spinous process Fx in back.**

DISPOSITION

PATIENT: Disposition Type: Discharge. (Thu Mar 09, 2017 10:24 BEN)
Disposition: Home, Disposition Transport: Friend/family driving, Condition: Improved, Patient left

the department. (Thu Mar 09, 2017 12:25 SEAR)

HPI BLANK (Thu Mar 09, 2017 08:59 BEN)

CHIEF COMPLAINT: **32 y/o WM was a rest driver in a front impact MVC at 70 mph, then roughed up by the police as he was attempting to evade. TF here with multiple facial Fx and a scrotal u/s showing decreased flow to the left testicle.**

HISTORIAN: History provided by patient.

TIME COURSE: **Sudden onset of symptoms, Symptoms are worsening, are constant.**

SEVERITY: **Maximum severity of symptoms moderate, Currently symptoms are moderate, In my professional medical judgment as a board-certified physician or other qualified personnel, this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part.**

ROS

CONSTITUTIONAL: Historian denies chills, Historian denies fever. (Thu Mar 09, 2017 09:07 BEN)

ENT: Historian denies epistaxis, Historian denies sore throat. (Thu Mar 09, 2017 09:07 BEN)

CARDIOVASCULAR: Historian denies chest pain, Historian denies syncope. (Thu Mar 09, 2017 09:07 BEN)

RESPIRATORY: Historian denies cough, Historian denies shortness of breath. (Thu Mar 09, 2017 09:07 BEN)

GI: Historian denies abdominal pain, Historian denies nausea, Historian denies vomiting. (Thu Mar 09, 2017 09:07 BEN)

GENITOURINARY MALE: Historian denies penile discharge, Historian denies urinary frequency, scrotal pain. (Thu Mar 09, 2017 09:06 BEN)

MUSCULOSKELETAL: Historian denies back pain, **Historian reports fall, injury.** Historian denies myalgias, Historian denies neck pain. (Thu Mar 09, 2017 09:06 BEN)

SKIN: Historian denies cellulitis, Historian denies induration, Historian denies rash, **Historian reports skin changes.** (Thu Mar 09, 2017 09:06 BEN)

NEUROLOGIC: **Historian reports headache**, Historian denies paralysis, Historian denies paresthesias, Historian denies sensory changes, Historian denies speech changes. (Thu Mar 09, 2017 09:06 BEN)

PSYCHIATRIC: Historian denies homicidal ideation, Historian denies suicidal ideation. (Thu Mar 09, 2017 09:07 BEN)

PHYSICAL EXAM (Thu Mar 09, 2017 09:07 BEN)

CONSTITUTIONAL: Vital signs reviewed, Patient appears non toxic, Patient alert and oriented to person, place and time.

HEAD: **multiple areas of CTx to face, swelling. Lac s/p repair L brow. Hemostatic.**

EYES: Extraocular muscles intact, Sclera normal.

NECK: Neck exam included findings of normal range of motion, Trachea midline.

RESPIRATORY CHEST: Respiratory exam included findings of no respiratory distress, Breath sounds clear, No wheezing, No rales, No rhonchi, **Tenderness, moderate, to the right anterior chest, Palpation of chest reproduces symptoms.**

CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm, Heart sounds normal.

ABDOMEN MALE: Abdominal exam included findings of abdomen nontender, no distension.

UPPER EXTREMITY: Upper extremity exam included findings of inspection normal, Range of motion normal.

LOWER EXTREMITY: **TTP/pain with ROM L knee and hip. B knee abrasions.**

SKIN: dry, no rash.
PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time, Normal affect.
NOTES: Notes: other than as noted above, all long bones and joints were palpated and ranged and were non-TTP and painless to range.

PAST MEDICAL HISTORY (Thu Mar 09, 2017 08:54 SEAR)

MEDICAL HISTORY: **No past medical history.**
SURGICAL HISTORY MALE: **Surgical history of orthopedic surgery, femur.**
PSYCHIATRIC HISTORY: **No previous psychiatric history.**
SOCIAL HISTORY: **Patient currently uses tobacco, Patient smokes cigarettes, daily, Patient smokes 1 pack per day, Patient denies alcohol use, Patient currently uses drugs, abuses marijuana, Social drug use.**

PROBLEM LIST

Only confirmed problems are displayed:

Problem Name	Status	Date Diagnosed	Date Resolved	Confirm Status
Blunt Chest Trauma (by history)	Active	Mon Aug 25, 2014		Confirmed
Contusion to the Head (by history)	Active	Mon Aug 25, 2014		Confirmed
facial fractures	Active	Thu Mar 09, 2017		Confirmed
scrotal contusion	Active	Thu Mar 09, 2017		Confirmed
spinous process Fx in back	Active	Thu Mar 09, 2017		Confirmed

CURRENT MEDICATIONS (Thu Mar 09, 2017 09:36 LVAR)

Patient states – No home medicines.

KNOWN ALLERGIES

No Known Drug Allergies

EVENTS

TRANSFER: Triage to Emergency Baroness ED 08. (Thu Mar 09, 2017 07:58 AHUN)
Emergency Baroness ED 08 to 07. (Thu Mar 09, 2017 10:35 SEAR)
Removed from Emergency Baroness ED 07. (Thu Mar 09, 2017 12:25 SEAR)

DOCTOR NOTES

NOTES: **paged Urology re: testicular injury.** (Thu Mar 09, 2017 09:10 BEN)
D/w Dr Smith Urology resident – pt does not need emergent surgical intervention. Expectant management, pain control. F/u 2 weeks in office. (Thu Mar 09, 2017 09:14 BEN)
d/w plastics no need for f/u unless unsightly after swelling resolves. (Thu Mar 09, 2017 11:15 BEN)

RESULTS (Thu Mar 09, 2017 09:21 BEN)

RADIOLOGY: CT THORAX ABD PELVIS W IV CONT Thu Mar 09, 2017 08:17,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: CHEST, ABD TRAUMA
ORDER COMMENTS: BEH-ED 08
ECT CT THORAX ABD PELVIS W IV CONT – 03/09/2017 08:50 AM – CPT: 71260, 74177, 74177
COMPARISON: None.
HISTORY: Motor vehicle accident.
TECHNIQUE: Multidetector helical CT acquisition through the chest, abdomen, and pelvis is provided after IV administration of 100 mL of Omnipaque 300. Coronal and sagittal multiplanar reformatted images are provided. Automated dose control was used for these exams.

FINDINGS:
Chest:
There is mild dependent atelectasis at the bilateral lung bases. No suspicious pulmonary nodules or masses are seen. There is no evidence of pneumothorax. The heart size is within normal limits. No pericardial effusion. There is mild stranding within the anterior mediastinum without discrete hematoma. A focal area of gas is seen along the left half of the sternomanubrial joint. No underlying fracture is seen. No definite rib fractures are seen. The thoracic aorta is normal in caliber. The extra thoracic soft tissues are within normal limits. Normal attenuation of the imaged thyroid gland.
Abdomen/Pelvis:
Normal appearance of the liver. No focal hepatic mass. There is no evidence of laceration. No perihepatic free fluid. Normal appearance of the gallbladder. Normal appearance of the spleen. No evidence of active extravasation or laceration. Normal appearance of the kidneys. The adrenal glands are normal without mass or nodularity. Normal appearance of the pancreas.
The stomach and duodenum appear normal. The small and large bowel are normal in caliber. No focal wall thickening or dilatation. No free fluid. No drainable fluid collections. Normal CT appearance of the prostate gland and seminal vesicles. Normal appearance of the bladder. There is asymmetric enlargement of the left psoas muscle with adjacent stranding. No evidence of active extravasation.
Fractures are present through the left L1–L4 transverse processes. No pelvic fractures are identified. The SI joints and pubic symphysis are intact. The vertebral body heights are well–maintained. Schmorls nodes are present along the inferior endplates of the lower thoracic vertebral bodies. A Schmorls node is seen along the superior endplate of an upper thoracic vertebral body. There is no evidence of vertebral body fracture. The posterior elements are within normal limits.
IMPRESSION: There is mild stranding within the anterior mediastinal fat which could represent contusion without hematoma. A small amount of gas adjacent to the sternomanubrial joint may also be associated with blunt trauma without acute fracture.
Fractures through the left L1–L4 transverse processes with asymmetric enlargement of the left psoas muscle. No active extravasation.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 09:06 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 09:15 AM
TRANSCRIBED BY: – PSC – 03/09/2017 09:15 AM
CC: EMCARE, PHYSICIAN .

CHEST SINGLE VIEW Thu Mar 09, 2017 08:29,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMATIC INJURY
ORDER COMMENTS: BEH–ED 08
E/R CHEST SINGLE VIEW – 03/09/2017 08:44 AM – CPT: 71010
HISTORY: TRAUMATIC INJURY.
COMPARISON: None.
TECHNIQUE: Single AP view the chest
RESULTS:
The heart size is normal in appearance. The pulmonary vasculature is mildly congested which is likely related to supine technique. There is no evidence of pneumothorax. No mediastinal shift. No displaced

rib fractures are seen. No subcutaneous emphysema. The trachea is midline.
IMPRESSION: Pulmonary venous congestion at least in part due to supine technique. No pneumothorax is seen.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 08:58 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 09:00 AM
TRANSCRIBED BY: – PSC – 03/09/2017 09:00 AM
CC: EMCARE, PHYSICIAN .

KNEE 3 VIEWS Thu Mar 09, 2017 08:17,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMA, PAIN
ORDER COMMENTS: BEH–ED 08
E/R KNEE 3 VIEWS L – 03/09/2017 08:44 AM – CPT: 73562
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well–maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well–maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 08:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 08:56 AM
TRANSCRIBED BY: – PSC – 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN .

HIP UNI 2–3 VWS Thu Mar 09, 2017 08:17,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMA, PAIN
ORDER COMMENTS: BEH–ED 08
E/R HIP UNI 2–3 VWS L – 03/09/2017 08:43 AM – CPT: 73502
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well–maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well–maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant

soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 08:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 08:56 AM
TRANSCRIBED BY: – PSC – 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN .

PELVIS 1 OR 2 VIEWS Thu Mar 09, 2017 08:29,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMATIC INJURY
ORDER COMMENTS: BEH–ED 08
E/R PELVIS 1 OR 2 VIEWS – 03/09/2017 08:46 AM – CPT: 72170
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well–maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well–maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 08:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 08:56 AM
TRANSCRIBED BY: – PSC – 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN .

LABORATORY:

Measurement	Result	Units	Range
BLOOD GAS ANALY RESP CARE Thu Mar 09, 2017 08:32			
RPH	7.44		7.35–7.45
RPCO2	35	MMHG	35–45
RPO2	84	MMHG	80–100
RHCO3	24	MEQ	22–28
RBE			
RO2HB	97	%	95–100
RFIO2	21	%	
RSITE	LEFT FEMORAL		
RVS	if critical values		
	see chart for		
	notification		

Measurement	Result	Units	Range
UREA NITROGEN ISTAT Thu Mar 09, 2017 08:31			
UNI	19	MG/DL	9–21

BARONESS ERLANGER EMERGENCY DEPARTMENT EMERGENCY RECORD

Koger, Phillip Wayne
DOB: 1984 M32
Wt/Ht: 102.1 Kg 187 cm.
MedRec: 01171273
AcctNum: 120246350

Measurement	Result	Units	Range
SODIUM ISTAT Thu Mar 09, 2017 08:31			
NAI	139	MMOL/L	135–153

Measurement	Result	Units	Range
POTASSIUM ISTAT Thu Mar 09, 2017 08:31			
KI	4.8	MMOL/L	3.5–5.3

Measurement	Result	Units	Range
IONIZED CA ISTAT Thu Mar 09, 2017 08:31			
IICA	**1.10**	**MMOL/L**	**1.12–1.32**

Measurement	Result	Units	Range
HEMATOCRIT ISTAT Thu Mar 09, 2017 08:31			
IHCT	**54**	**%**	**42–52**

Measurement	Result	Units	Range
CO2 Thu Mar 09, 2017 08:31			
ICO2	23	MMOL/L	23–27

Measurement	Result	Units	Range
GLUCOSE ISTAT Thu Mar 09, 2017 08:31			
GLUI	**127**	**MG/DL**	**70–105**

Measurement	Result	Units	Range
CREATININE ISTAT Thu Mar 09, 2017 08:31			
CRETI	1.2	MG/DL	0.8–1.5

Measurement	Result	Units	Range
CHLORIDE ISTAT Thu Mar 09, 2017 08:31			
CLI	104	MMOL/L	97–107

ORDER DETAILS

Order Name	Status	Time	User
BEH EKG Order Notification	Done	10:21 3/9/2017	ZATE
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
CHEST, SINGLE VIEW	Done	09:02 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Jackson, TNS, Jana L – Thu Mar 09, 2017 08:29			
– Quantity: 1			
– Reason: Traumatic Injury			
– Transportation Method: PORTABLE AT BEDSIDE			
– Pregnant: No			
EKG 12 LEAD – BEH	Active	08:17 3/9/2017	BEN
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
– Reason: Chest Trauma			
HIP UNILAT 2–3 VWS	Done	08:59 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			

– Quantity: 1			
– Reason: trauma, pain			
– Left/Right Indicator: Left			
– Transportation Method: STRETCHER – SEND TO DEPT			
– Pregnant: No			
iSTAT 10– Na, K Cl TCO2 Glu BUN Cr iCa Hct	Done	08:28 3/9/2017	BMI1
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
ISTAT ABG–Page Respiratory	Done	08:28 3/9/2017	BMI1
– Ordered for: Smith, MD, Benjamin			
– Entered by: Miller, RT, Barry G – Thu Mar 09, 2017 08:28			
– Quantity: 1			
KNEE 3 VIEWS	Done	08:59 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
– Reason: trauma, pain			
– Transportation Method: PORTABLE AT BEDSIDE			
– Pregnant: No			
PELVIS 1 OR 2 VIEWS	Done	08:58 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Jackson, TNS, Jana L – Thu Mar 09, 2017 08:29			
– Quantity: 1			
– Reason: Traumatic Injury			
– Transportation Method: STRETCHER – SEND TO DEPT			
– Pregnant: No			
PO fluids, call family to pick up pt	Done	11:16 3/9/2017	SEAR
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 10:51			
– Quantity: 1			
Saline Lock x 2	Done	08:23 3/9/2017	SEAR
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
– Reason: trauma to chest/abd			
THORAX ABDOMEN PELVIS W/CONTRAST	Done	09:17 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
– Reason: chest, abd trauma			
– Transportation Method: STRETCHER – SEND TO DEPT			
– Pregnant: No			

PRESCRIPTION (Thu Mar 09, 2017 10:27 BEN)

Percocet: TABLET : 7.5 mg–325 mg : ORAL : Quantity: *** 1 *** Unit: TAB Route: ORAL Schedule: Every four to six hours as needed. Dispense: *** 30 ***.

NOTES: **Substitution Permitted**
NO REFILLS.

Zofran Tab: TABLET : 4 mg : ORAL : Quantity: *** 1 *** Unit: TAB Route: ORAL Schedule: Every four to six hours as needed. Dispense: *** 21 ***.

NOTES

INSTRUCTION (Thu Mar 09, 2017 10:34 BEN)

DISCHARGE: FRACTURED NOSE.

FOLLOWUP: None. Patient has, no PCP– See referral, Clinics, PHYSICIAN REFERRAL TO, UT ERLANGER PHYSICIANS GROUP, 423–778–DOCS (3627), Call UT Erlanger

Physicians Group Referral line to help locate a physician., Urologists, Academic, UT. Clinics / Erlanger Practice, at Erlanger, Suite C-925, 979 East Third Street, Chattanooga TN 37311, 423-778-5910, Follow up with Specialist Call the office and make an appointment.

SPECIAL: (20) Follow up with Urology within 2 weeks.

NURSING PROCEDURE: EKG CHART (Thu Mar 09, 2017 10:21 ZATE)

PATIENT IDENTIFIER: Patient's identity verified by patient stating name, Patient's identity verified by patient stating birth date, Patient's identity verified by hospital ID bracelet.

EKG: EKG indicated for Facial fx, 12 lead EKG performed on the left chest, done by zat, first EKG, EKG Shown to Dr. Smith.

FOLLOW-UP: After procedure, EKG for interpretation given to Dr. Smith.

NOTES: Patient tolerated procedure well.

SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on, Patient in view of the nursing station.

IMAGING

EKG-EMERGENCY DEPARTMENT: Image captured from scanner. (Thu Mar 09, 2017 10:42 KINS)

TRAUMA CHART: Image captured from scanner. (Thu Mar 09, 2017 12:24 SEAR)

Page 002 added. Image captured from scanner. (Thu Mar 09, 2017 12:24 SEAR)

Page 003 added. Image captured from scanner. (Thu Mar 09, 2017 12:25 SEAR)

Page 004 added. Image captured from scanner. (Thu Mar 09, 2017 12:25 SEAR)

Key:

AHUN=Hunzelman, RN, Ashley L BEN=Smith, MD, Benjamin KINS=Kinsey, UC, Stephanie LVAR=Varner, CPH T, Lee SEAR=Armstrong, RN, Sarah E ZATE=Terrell, ER TECH, Zachary A

BARONESS ERLANGER EMERGENCY DEPARTMENT EMERGENCY RECORD

Koger, Phillip Wayne
DOB: [redacted]984 M32
Wt/Ht: 102.1 Kg 187 cm.
MedRec: 01171273
AcctNum: 120246350

Patient Data

Complaint: facial fractures
Triage Time: Thu Mar 09, 2017 07:58
Urgency: ESI Level 2
Bed: ED BEH-ED
Initial Vital Signs:
BP:
P:
O2 sat:
ED Attending: Smith, MD, Benjamin
Primary RN: Armstrong, RN, Sarah E
R:
T:
Pain:

TRIAGE (Thu Mar 09, 2017 07:58 AHUN)

TRIAGE NOTES: Patient presents to ED s/p mvc. pt was unrestrained driver of vehicle high speed chase from the police that lost control of the car. Pt transfer from Cornerstone for facial fractures., SEASON FLU/2013 NOVEL VIRUS/EBOLA SCREENING / Enterovirus D68: The patient does not have a sore throat, Temp is less than 100.0F, no cough, no sneezing, no rhinorrhea or nasal congestion, no dyspnea, no flul-like symptoms, The patient has NO recent travel outside the United States within the last 21 days., Taken directly to treatment room for triage or by EMS. (Thu Mar 09, 2017 07:58 AHUN)

COMPLAINT: facial fractures. (Thu Mar 09, 2017 07:58 AHUN)

MEASLES SCREEN: no rhinorrhea, Temp is less than 105.0F, no cough, no conjunctivitis, no rash, **A face mask was not applied to the patient.** (Thu Mar 09, 2017 08:54 SEAR)

PATIENT: AGE: 32, GENDER: male, DOB: [redacted]1984, PRE-HOSPITAL NOTIFICATION: Thu Mar 09, 2017 07:31, RACE: White, Not Hispanic, Holiday, Event, MCI: No, Travel outside US?: No recent travel outside the U.S., Isolation Precaution: Standard Precautions, Latex Allergy: No Latex Allergy, Patient Origin: Hutcheson Med Ctr - Ft Oglethorp GA, PCP/Special: None. Patient has, no PCP- See. (Thu Mar 09, 2017 07:58 AHUN)

NAME: Koger, Phillip Wayne. (Thu Mar 09, 2017 08:00)

KG WEIGHT: 102.1, HEIGHT: 187cm, BMI: 29.20. (Thu Mar09, 2017 08:54 SEAR)

KG WEIGHT: 102.1, HEIGHT: 187cm, BMI: 29.20. (Thu Mar09, 2017 08:54 SEAR)

TRIAGE INFORMATION: Pain level 6 Hurts Even More, using faces pain scoring. (Thu Mar 09, 2017 08:54 SEAR)

TREATMENTS IN PROGRESS: EMS/First Responder/By-stander care prior to arrival, Arrived via EMS, **Patient transferred from another facility**, Transferring facility: **cornerstone.** (Thu Mar09, 2017 08:54 SEAR)

SPECIAL NEEDS: No special needs identified, Do you communicate in a language other than English at home? NO, English is used., No accommodations are requested. (Thu Mar 09, 2017 08:54 SEAR)

ADMISSION: URGENCY: ESI Level 2, ADMISSION SOURCE: Ambulance - Puckett EMS, AMBULANCE: Puckett EMS, TRANSPORT: Stretcher, BED: BEH-ED 08. (Thu Mar 09, 2017 07:58 AHUN)

PROVIDERS: TRIAGE NURSE: Ashley L Hunzelman, RN. (Thu Mar 09, 2017 07:58 AHUN)

ESI ALGORITHM: ES level 2. (Thu Mar 09, 2017 08:54 SEAR)

PREVIOUS VISIT ALLERGIES: No Known Drug Allergies. (Thu Mar 09, 2017 08:54 SEAR)

AMBULANCE (Thu Mar 09, 2017 07:31 AHUN)

AMBULANCE: Ambulance: Thu Mar 09, 2017 07:31.

DIAGNOSIS (Thu Mar 09, 2017 10:24 BEN)

FINAL: PRIMARY: **facial fractures**, ADDITIONAL: **scrotal contusion, spinous process Fx in back.**

DISPOSITION

PATIENT: Disposition Type: Discharge. (Thu Mar 09, 2017 10:24 BEN)
Disposition: Home, Disposition Transport: Friend/family driving, Condition: Improved, Patient left

the department. (Thu Mar 09, 2017 12:25 SEAR)

HPI BLANK (Thu Mar 09, 2017 08:59 BEN)

CHIEF COMPLAINT: **32 y/o WM was a rest driver in a front impact MVC at 70 mph, then roughed up by the police as he was attempting to evade. TF here with multiple facial Fx and a scrotal u/s showing decreased flow to the left testicle.**

HISTORIAN: History provided by patient.

TIME COURSE: **Sudden onset of symptoms, Symptoms are worsening, are constant.**

SEVERITY: **Maximum severity of symptoms moderate, Currently symptoms are moderate, In my professional medical judgment as a board-certified physician or other qualified personnel, this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part.**

ROS

CONSTITUTIONAL: Historian denies chills, Historian denies fever. (Thu Mar 09, 2017 09:07 BEN)

ENT: Historian denies epistaxis, Historian denies sore throat. (Thu Mar 09, 2017 09:07 BEN)

CARDIOVASCULAR: Historian denies chest pain, Historian denies syncope. (Thu Mar 09, 2017 09:07 BEN)

RESPIRATORY: Historian denies cough, Historian denies shortness of breath. (Thu Mar 09, 2017 09:07 BEN)

GI: Historian denies abdominal pain, Historian denies nausea, Historian denies vomiting. (Thu Mar 09, 2017 09:07 BEN)

GENITOURINARY MALE: Historian denies penile discharge, Historian denies urinary frequency, scrotal pain. (Thu Mar 09, 2017 09:06 BEN)

MUSCULOSKELETAL: Historian denies back pain, **Historian reports fall, injury.** Historian denies myalgias, Historian denies neck pain. (Thu Mar 09, 2017 09:06 BEN)

SKIN: Historian denies cellulitis, Historian denies induration, Historian denies rash, **Historian reports skin changes.** (Thu Mar 09, 2017 09:06 BEN)

NEUROLOGIC: **Historian reports headache**, Historian denies paralysis, Historian denies paresthesias, Historian denies sensory changes, Historian denies speech changes. (Thu Mar 09, 2017 09:06 BEN)

PSYCHIATRIC: Historian denies homicidal ideation, Historian denies suicidal ideation. (Thu Mar 09, 2017 09:07 BEN)

PHYSICAL EXAM (Thu Mar 09, 2017 09:07 BEN)

CONSTITUTIONAL: Vital signs reviewed, Patient appears non toxic, Patient alert and oriented to person, place and time.

HEAD: **multiple areas of CTx to face, swelling. Lac s/p repair L brow. Hemostatic.**

EYES: Extraocular muscles intact, Sclera normal.

NECK: Neck exam included findings of normal range of motion, Trachea midline.

RESPIRATORY CHEST: Respiratory exam included findings of no respiratory distress, Breath sounds clear, No wheezing, No rales, No rhonchi, **Tenderness, moderate, to the right anterior chest, Palpation of chest reproduces symptoms.**

CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm, Heart sounds normal.

ABDOMEN MALE: Abdominal exam included findings of abdomen nontender, no distension.

UPPER EXTREMITY: Upper extremity exam included findings of inspection normal, Range of motion normal.

LOWER EXTREMITY: **TTP/pain with ROM L knee and hip. B knee abrasions.**

SKIN: dry, no rash.
PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time, Normal affect.
NOTES: Notes: other than as noted above, all long bones and joints were palpated and ranged and were non-TTP and painless to range.

PAST MEDICAL HISTORY (Thu Mar 09, 2017 08:54 SEAR)

MEDICAL HISTORY: **No past medical history.**
SURGICAL HISTORY MALE: **Surgical history of orthopedic surgery, femur.**
PSYCHIATRIC HISTORY: **No previous psychiatric history.**
SOCIAL HISTORY: **Patient currently uses tobacco, Patient smokes cigarettes, daily, Patient smokes 1 pack per day, Patient denies alcohol use, Patient currently uses drugs, abuses marijuana, Social drug use.**

PROBLEM LIST

Only confirmed problems are displayed:

Problem Name	Status	Date Diagnosed	Date Resolved	Confirm Status
Blunt Chest Trauma (by history)	Active	Mon Aug 25, 2014		Confirmed
Contusion to the Head (by history)	Active	Mon Aug 25, 2014		Confirmed
facial fractures	Active	Thu Mar 09, 2017		Confirmed
scrotal contusion	Active	Thu Mar 09, 2017		Confirmed
spinous process Fx in back	Active	Thu Mar 09, 2017		Confirmed

CURRENT MEDICATIONS (Thu Mar 09, 2017 09:36 LVAR)

Patient states – No home medicines.

KNOWN ALLERGIES

No Known Drug Allergies

EVENTS

TRANSFER: Triage to Emergency Baroness ED 08. (Thu Mar 09, 2017 07:58 AHUN)
Emergency Baroness ED 08 to 07. (Thu Mar 09, 2017 10:35 SEAR)
Removed from Emergency Baroness ED 07. (Thu Mar 09, 2017 12:25 SEAR)

DOCTOR NOTES

NOTES: **paged Urology re: testicular injury.** (Thu Mar 09, 2017 09:10 BEN)
D/w Dr Smith Urology resident – pt does not need emergent surgical intervention. Expectant management, pain control. F/u 2 weeks in office. (Thu Mar 09, 2017 09:14 BEN)
d/w plastics no need for f/u unless unsightly after swelling resolves. (Thu Mar 09, 2017 11:15 BEN)

RESULTS (Thu Mar 09, 2017 09:21 BEN)

RADIOLOGY: CT THORAX ABD PELVIS W IV CONT Thu Mar 09, 2017 08:17,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: CHEST, ABD TRAUMA
ORDER COMMENTS: BEH-ED 08
ECT CT THORAX ABD PELVIS W IV CONT – 03/09/2017 08:50 AM – CPT: 71260, 74177, 74177
COMPARISON: None.
HISTORY: Motor vehicle accident.
TECHNIQUE: Multidetector helical CT acquisition through the chest, abdomen, and pelvis is provided after IV administration of 100 mL of Omnipaque 300. Coronal and sagittal multiplanar reformatted images are provided. Automated dose control was used for these exams.

FINDINGS:
Chest:
There is mild dependent atelectasis at the bilateral lung bases. No suspicious pulmonary nodules or masses are seen. There is no evidence of pneumothorax. The heart size is within normal limits. No pericardial effusion. There is mild stranding within the anterior mediastinum without discrete hematoma. A focal area of gas is seen along the left half of the sternomanubrial joint. No underlying fracture is seen. No definite rib fractures are seen. The thoracic aorta is normal in caliber. The extra thoracic soft tissues are within normal limits. Normal attenuation of the imaged thyroid gland.
Abdomen/Pelvis:
Normal appearance of the liver. No focal hepatic mass. There is no evidence of laceration. No perihepatic free fluid. Normal appearance of the gallbladder. Normal appearance of the spleen. No evidence of active extravasation or laceration. Normal appearance of the kidneys. The adrenal glands are normal without mass or nodularity. Normal appearance of the pancreas.
The stomach and duodenum appear normal. The small and large bowel are normal in caliber. No focal wall thickening or dilatation. No free fluid. No drainable fluid collections. Normal CT appearance of the prostate gland and seminal vesicles. Normal appearance of the bladder. There is asymmetric enlargement of the left psoas muscle with adjacent stranding. No evidence of active extravasation.
Fractures are present through the left L1–L4 transverse processes. No pelvic fractures are identified. The SI joints and pubic symphysis are intact. The vertebral body heights are well–maintained. Schmorls nodes are present along the inferior endplates of the lower thoracic vertebral bodies. A Schmorls node is seen along the superior endplate of an upper thoracic vertebral body. There is no evidence of vertebral body fracture. The posterior elements are within normal limits.
IMPRESSION: There is mild stranding within the anterior mediastinal fat which could represent contusion without hematoma. A small amount of gas adjacent to the sternomanubrial joint may also be associated with blunt trauma without acute fracture.
Fractures through the left L1–L4 transverse processes with asymmetric enlargement of the left psoas muscle. No active extravasation.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 09:06 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 09:15 AM
TRANSCRIBED BY: – PSC – 03/09/2017 09:15 AM
CC: EMCARE, PHYSICIAN .

CHEST SINGLE VIEW Thu Mar 09, 2017 08:29,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMATIC INJURY
ORDER COMMENTS: BEH–ED 08
E/R CHEST SINGLE VIEW – 03/09/2017 08:44 AM – CPT: 71010
HISTORY: TRAUMATIC INJURY.
COMPARISON: None.
TECHNIQUE: Single AP view the chest
RESULTS:
The heart size is normal in appearance. The pulmonary vasculature is mildly congested which is likely related to supine technique. There is no evidence of pneumothorax. No mediastinal shift. No displaced

rib fractures are seen. No subcutaneous emphysema. The trachea is midline.
IMPRESSION: Pulmonary venous congestion at least in part due to supine technique. No pneumothorax is seen.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 08:58 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 09:00 AM
TRANSCRIBED BY: – PSC – 03/09/2017 09:00 AM
CC: EMCARE, PHYSICIAN .

KNEE 3 VIEWS Thu Mar 09, 2017 08:17,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMA, PAIN
ORDER COMMENTS: BEH–ED 08
E/R KNEE 3 VIEWS L – 03/09/2017 08:44 AM – CPT: 73562
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well–maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well–maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 08:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 08:56 AM
TRANSCRIBED BY: – PSC – 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN .

HIP UNI 2–3 VWS Thu Mar 09, 2017 08:17,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMA, PAIN
ORDER COMMENTS: BEH–ED 08
E/R HIP UNI 2–3 VWS L – 03/09/2017 08:43 AM – CPT: 73502
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well–maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well–maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant

soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 08:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 08:56 AM
TRANSCRIBED BY: – PSC – 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN .

PELVIS 1 OR 2 VIEWS Thu Mar 09, 2017 08:29,
ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMATIC INJURY
ORDER COMMENTS: BEH–ED 08
E/R PELVIS 1 OR 2 VIEWS – 03/09/2017 08:46 AM – CPT: 72170
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well–maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well–maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD – 03/09/2017 08:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD – 03/09/2017 08:56 AM
TRANSCRIBED BY: – PSC – 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN .

LABORATORY:

Measurement	Result	Units	Range
BLOOD GAS ANALY RESP CARE Thu Mar 09, 2017 08:32			
RPH	7.44		7.35–7.45
RPCO2	35	MMHG	35–45
RPO2	84	MMHG	80–100
RHCO3	24	MEQ	22–28
RBE			
RO2HB	97	%	95–100
RFIO2	21	%	
RSITE	LEFT FEMORAL		
RVS	if critical values		
	see chart for		
	notification		

Measurement	Result	Units	Range
UREA NITROGEN ISTAT Thu Mar 09, 2017 08:31			
UNI	19	MG/DL	9–21

BARONESS ERLANGER EMERGENCY DEPARTMENT EMERGENCY RECORD

Koger, Phillip Wayne
DOB: 1984 M32
Wt/Ht: 102.1 Kg 187 cm.
MedRec: 01171273
AcctNum: 120246350

Measurement	Result	Units	Range
SODIUM ISTAT Thu Mar 09, 2017 08:31			
NAI	139	MMOL/L	135–153

Measurement	Result	Units	Range
POTASSIUM ISTAT Thu Mar 09, 2017 08:31			
KI	4.8	MMOL/L	3.5–5.3

Measurement	Result	Units	Range
IONIZED CA ISTAT Thu Mar 09, 2017 08:31			
IICA	**1.10**	**MMOL/L**	**1.12–1.32**

Measurement	Result	Units	Range
HEMATOCRIT ISTAT Thu Mar 09, 2017 08:31			
IHCT	**54**	**%**	**42–52**

Measurement	Result	Units	Range
CO2 Thu Mar 09, 2017 08:31			
ICO2	23	MMOL/L	23–27

Measurement	Result	Units	Range
GLUCOSE ISTAT Thu Mar 09, 2017 08:31			
GLUI	**127**	**MG/DL**	**70–105**

Measurement	Result	Units	Range
CREATININE ISTAT Thu Mar 09, 2017 08:31			
CRETI	1.2	MG/DL	0.8–1.5

Measurement	Result	Units	Range
CHLORIDE ISTAT Thu Mar 09, 2017 08:31			
CLI	104	MMOL/L	97–107

ORDER DETAILS

Order Name	Status	Time	User
BEH EKG Order Notification	Done	10:21 3/9/2017	ZATE
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
CHEST, SINGLE VIEW	Done	09:02 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Jackson, TNS, Jana L – Thu Mar 09, 2017 08:29			
– Quantity: 1			
– Reason: Traumatic Injury			
– Transportation Method: PORTABLE AT BEDSIDE			
– Pregnant: No			
EKG 12 LEAD – BEH	Active	08:17 3/9/2017	BEN
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
– Reason: Chest Trauma			
HIP UNILAT 2–3 VWS	Done	08:59 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			

– Quantity: 1			
– Reason: trauma, pain			
– Left/Right Indicator: Left			
– Transportation Method: STRETCHER – SEND TO DEPT			
– Pregnant: No			
iSTAT 10– Na, K Cl TCO2 Glu BUN Cr iCa Hct	Done	08:28 3/9/2017	BMI1
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
ISTAT ABG–Page Respiratory	Done	08:28 3/9/2017	BMI1
– Ordered for: Smith, MD, Benjamin			
– Entered by: Miller, RT, Barry G – Thu Mar 09, 2017 08:28			
– Quantity: 1			
KNEE 3 VIEWS	Done	08:59 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
– Reason: trauma, pain			
– Transportation Method: PORTABLE AT BEDSIDE			
– Pregnant: No			
PELVIS 1 OR 2 VIEWS	Done	08:58 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Jackson, TNS, Jana L – Thu Mar 09, 2017 08:29			
– Quantity: 1			
– Reason: Traumatic Injury			
– Transportation Method: STRETCHER – SEND TO DEPT			
– Pregnant: No			
PO fluids, call family to pick up pt	Done	11:16 3/9/2017	SEAR
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 10:51			
– Quantity: 1			
Saline Lock x 2	Done	08:23 3/9/2017	SEAR
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
– Reason: trauma to chest/abd			
THORAX ABDOMEN PELVIS W/CONTRAST	Done	09:17 3/9/2017	System
– Ordered for: Smith, MD, Benjamin			
– Entered by: Smith, MD, Benjamin – Thu Mar 09, 2017 08:17			
– Quantity: 1			
– Reason: chest, abd trauma			
– Transportation Method: STRETCHER – SEND TO DEPT			
– Pregnant: No			

PRESCRIPTION (Thu Mar 09, 2017 10:27 BEN)

Percocet: TABLET : 7.5 mg–325 mg : ORAL : Quantity: *** 1 *** Unit: TAB Route: ORAL Schedule: Every four to six hours as needed. Dispense: *** 30 ***.

NOTES: **Substitution Permitted**
NO REFILLS.

Zofran Tab: TABLET : 4 mg : ORAL : Quantity: *** 1 *** Unit: TAB Route: ORAL Schedule: Every four to six hours as needed. Dispense: *** 21 ***.

NOTES

INSTRUCTION (Thu Mar 09, 2017 10:34 BEN)

DISCHARGE: FRACTURED NOSE.

FOLLOWUP: None. Patient has, no PCP– See referral, Clinics, PHYSICIAN REFERRAL TO, UT ERLANGER PHYSICIANS GROUP, 423–778–DOCS (3627), Call UT Erlanger

Physicians Group Referral line to help locate a physician., Urologists, Academic, UT. Clinics / Erlanger Practice, at Erlanger, Suite C-925, 979 East Third Street, Chattanooga TN 37311, 423-778-5910, Follow up with Specialist Call the office and make an appointment.
SPECIAL: (20) Follow up with Urology within 2 weeks.

NURSING PROCEDURE: EKG CHART (Thu Mar 09, 2017 10:21 ZATE)
PATIENT IDENTIFIER: Patient's identity verified by patient stating name, Patient's identity verified by patient stating birth date, Patient's identity verified by hospital ID bracelet.
EKG: EKG indicated for Facial fx, 12 lead EKG performed on the left chest, done by zat, first EKG, EKG Shown to Dr. Smith.
FOLLOW-UP: After procedure, EKG for interpretation given to Dr. Smith.
NOTES: Patient tolerated procedure well.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on, Patient in view of the nursing station.

IMAGING
EKG-EMERGENCY DEPARTMENT: Image captured from scanner. (Thu Mar 09, 2017 10:42 KINS)
TRAUMA CHART: Image captured from scanner. (Thu Mar 09, 2017 12:24 SEAR)
Page 002 added. Image captured from scanner. (Thu Mar 09, 2017 12:24 SEAR)
Page 003 added. Image captured from scanner. (Thu Mar 09, 2017 12:25 SEAR)
Page 004 added. Image captured from scanner. (Thu Mar 09, 2017 12:25 SEAR)

ADMIN (Sun Mar 19, 2017 02:01 BEN)
DIGITAL SIGNATURE: Smith, MD, Benjamin.

Key:
AHUN=Hunzelman, RN, Ashley L BEN=Smith, MD, Benjamin KINS=Kinsey, UC, Stephanie LVAR=Varner, CPH T, Lee SEAR=Armstrong, RN, Sarah E ZATE=Terrell, ER TECH, Zachary A

BARONESS ERLANGER EMERGENCY DEPARTMENT EMERGENCY RECORD

Koger, Phillip Wayne
DOB: 1984 M32
Wt/Ht: 102.1 Kg 187 cm.
MedRec: 01171273
AcctNum: 120246350

Patient Data

Complaint: facial fractures
Triage Time: Thu Mar 09, 2017 07:58
Urgency: ESI Level 2
Bed: ED BEH-ED
Initial Vital Signs:
BP:
P:
O2 sat:

ED Attending: Smith, MD, Benjamin
Primary RN: Armstrong, RN, Sarah E

R:
T:
Pain:

TRIAGE (Thu Mar 09, 2017 07:58 AHUN)

TRIAGE NOTES: Patient presents to ED s/p mvc. pt was unrestrained driver of vehicle high speed chase from the police that lost control of the car. Pt transfer from Cornerstone for facial fractures., SEASON FLU/2013 NOVEL VIRUS/EBOLA SCREENING / Enterovirus D68: The patient does not have a sore throat, Temp is less than 100.0F, no cough, no sneezing, no rhinorrhea or nasal congestion, no dyspnea, no flul-like symptoms, The patient has NO recent travel outside the United States within the last 21 days., Taken directly to treatment room for triage or by EMS. (Thu Mar 09, 2017 07:58 AHUN)

COMPLAINT: facial fractures. (Thu Mar 09, 2017 07:58 AHUN)

MEASLES SCREEN: no rhinorrhea, Temp is less than 105.0F, no cough, no conjunctivitis, no rash, **A face mask was not applied to the patient.** (Thu Mar 09, 2017 08:54 SEAR)

PATIENT: AGE: 32, GENDER: male, DOB: ' 1984, PRE-HOSPITAL NOTIFICATION: Thu Mar 09, 2017 07:31, RACE: White, Not Hispanic, Holiday, Event, MCI: No, Travel outside US?: No recent travel outside the U.S., Isolation Precaution: Standard Precautions, Latex Allergy: No Latex Allergy, Patient Origin: Hutcheson Med Ctr - Ft Oglethorp GA, PCP/Special: None. Patient has, no PCP- See. (Thu Mar 09, 2017 07:58 AHUN)

NAME: Koger, Phillip Wayne. (Thu Mar 09, 2017 08:00)

KG WEIGHT: 102.1, HEIGHT: 187cm, BMI: 29.20. (Thu Mar 09, 2017 08:54 SEAR)

KG WEIGHT: 102.1, HEIGHT: 187cm, BMI: 29.20. (Thu Mar 09, 2017 08:54 SEAR)

TRIAGE INFORMATION: Pain level 6 Hurts Even More, using faces pain scoring. (Thu Mar 09, 2017 08:54 SEAR)

TREATMENTS IN PROGRESS: EMS/First Responder/By-stander care prior to arrival, Arrived via EMS, **Patient transferred from another facility**, Transferring facility: **cornerstone.** (Thu Mar 09, 2017 08:54 SEAR)

SPECIAL NEEDS: No special needs identified, Do you communicate in a language other than English at home? NO, English is used., No accommodations are requested. (Thu Mar 09, 2017 08:54 SEAR)

ADMISSION: URGENCY: ESI Level 2, ADMISSION SOURCE: Ambulance - Puckett EMS, AMBULANCE: Puckett EMS, TRANSPORT: Stretcher, BED: BEH-ED 08. (Thu Mar 09, 2017 07:58 AHUN)

PROVIDERS: TRIAGE NURSE: Ashley L Hunzelman, RN. (Thu Mar 09, 2017 07:58 AHUN)

ESI ALGORITHM: ES level 2. (Thu Mar 09, 2017 08:54 SEAR)

PREVIOUS VISIT ALLERGIES: No Known Drug Allergies. (Thu Mar 09, 2017 08:54 SEAR)

DIAGNOSIS (Thu Mar 09, 2017 10:24 BEN)

FINAL: PRIMARY: **facial fractures**, ADDITIONAL: **scrotal contusion, spinous process Fx in back.**

DISPOSITION

PATIENT: Disposition Type: Discharge. (Thu Mar 09, 2017 10:24 BEN)

Disposition: Home, Disposition Transport: Friend/family driving, Condition: Improved, Patient left the department. (Thu Mar 09, 2017 12:25 SEAR)

HPI BLANK (Thu Mar 09, 2017 08:59 BEN)

BARONESS ERLANGER EMERGENCY DEPARTMENT EMERGENCY RECORD

Koger, Phillip Wayne
DOB: 984 M32
Wt/Ht: 102.1 Kg 187 cm.
MedRec: 01171273
AcctNum: 120246350

CHIEF COMPLAINT: **32 y/o WM was a rest driver in a front impact MVC at 70 mph, then roughed up by the police as he was attempting to evade. TF here with multiple facial Fx and a scrotal u/s showing decreased flow to the left testicle.**
HISTORIAN: History provided by patient.
TIME COURSE: **Sudden onset of symptoms, Symptoms are worsening, are constant.**
SEVERITY: **Maximum severity of symptoms moderate, Currently symptoms are moderate, In my professional medical judgment as a board-certified physician or other qualified personnel, this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part.**

ROS

CONSTITUTIONAL: Historian denies chills, Historian denies fever. (Thu Mar 09, 2017 09:07 BEN)
ENT: Historian denies epistaxis, Historian denies sore throat. (Thu Mar 09, 2017 09:07 BEN)
CARDIOVASCULAR: Historian denies chest pain, Historian denies syncope. (Thu Mar 09, 2017 09:07 BEN)
RESPIRATORY: Historian denies cough, Historian denies shortness of breath. (Thu Mar 09, 2017 09:07 BEN)
GI: Historian denies abdominal pain, Historian denies nausea, Historian denies vomiting. (Thu Mar 09, 2017 09:07 BEN)
GENITOURINARY MALE: Historian denies penile discharge, Historian denies urinary frequency, scrotal pain. (Thu Mar 09, 2017 09:06 BEN)
MUSCULOSKELETAL: Historian denies back pain, **Historian reports fall, injury.** Historian denies myalgias, Historian denies neck pain. (Thu Mar 09, 2017 09:06 BEN)
SKIN: Historian denies cellulitis, Historian denies induration, Historian denies rash, **Historian reports skin changes.** (Thu Mar 09, 2017 09:06 BEN)
NEUROLOGIC: **Historian reports headache**, Historian denies paralysis, Historian denies paresthesias, Historian denies sensory changes, Historian denies speech changes. (Thu Mar 09, 2017 09:06 BEN)
PSYCHIATRIC: Historian denies homicidal ideation, Historian denies suicidal ideation. (Thu Mar 09, 2017 09:07 BEN)

PHYSICAL EXAM (Thu Mar 09, 2017 09:07 BEN)

CONSTITUTIONAL: Vital signs reviewed, Patient appears non toxic, Patient alert and oriented to person, place and time.
HEAD: **multiple areas of CTx to face, swelling. Lac s/p repair L brow. Hemostatic.**
EYES: Extraocular muscles intact, Sclera normal.
NECK: Neck exam included findings of normal range of motion, Trachea midline.
RESPIRATORY CHEST: Respiratory exam included findings of no respiratory distress, Breath sounds clear, No wheezing, No rales, No rhonchi, **Tenderness, moderate, to the right anterior chest, Palpation of chest reproduces symptoms.**
CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm, Heart sounds normal.
ABDOMEN MALE: Abdominal exam included findings of abdomen nontender, no distension.
UPPER EXTREMITY: Upper extremity exam included findings of inspection normal, Range of motion normal.
LOWER EXTREMITY: **TTP/pain with ROM L knee and hip. B knee abrasions.**
SKIN: dry, no rash.
PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time, Normal affect.

BARONESS ERLANGER EMERGENCY DEPARTMENT EMERGENCY RECORD

Koger, Phillip Wayne
DOB: 1984 M32
Wt/Ht: 102.1 Kg 187 cm.
MedRec: 01171273
AcctNum: 120246350

NOTES: Notes: other than as noted above, all long bones and joints were palpated and ranged and were non-TTP and painless to range.

PAST MEDICAL HISTORY (Thu Mar 09, 2017 03:54 SEAR)

MEDICAL HISTORY: **No past medical history.**
SURGICAL HISTORY MALE: **Surgical history of orthopedic surgery, femur.**
PSYCHIATRIC HISTORY: **No previous psychiatric history.**
SOCIAL HISTORY: **Patient currently uses tobacco, Patient smokes cigarettes, daily, Patient smokes 1 pack per day, Patient denies alcohol use, Patient currently uses drugs, abuses marijuana, Social drug use.**

PROBLEM LIST

Only confirmed problems are displayed:

Problem Name	Status	Date Diagnosed	Date Resolved	Confirm Status
Blunt Chest Trauma (by history)	Active	Mon Aug 25, 2014		Confirmed
Contusion to the Head (by history)	Active	Mon Aug 25, 2014		Confirmed
facial fractures	Active	Thu Mar 09, 2017		Confirmed
scrotal contusion	Active	Thu Mar 09, 2017		Confirmed
spinous process Fx in back	Active	Thu Mar 09, 2017		Confirmed

CURRENT MEDICATIONS (Thu Mar 09, 2017 09:36 LVAR)

Patient states – No home medicines.

KNOWN ALLERGIES

No Known Drug Allergies

DOCTOR NOTES

NOTES: **paged Urology re: testicular injury.** (Thu Mar 09, 2017 09:10 BEN)
D/w Dr Smith Urology resident – pt does not need emergent surgical intervention. Expectant management, pain control. F/u 2 weeks in office. (Thu Mar 09, 2017 09:14 BEN)
d/w plastics no need for f/u unless unsightly after swelling resolves. (Thu Mar 09, 2017 11:15 BEN)

PRESCRIPTION (Thu Mar 09, 2017 10:27 BEN)

Percocet: TABLET : 7.5 mg–325 mg : ORAL : Quantity: *** 1 *** Unit: TAB Route: ORAL Schedule: Every four to six hours as needed. Dispense: *** 30 ***.
NOTES: **Substitution Permitted**
NO REFILLS.
Zofran Tab: TABLET : 4 mg : ORAL : Quantity: *** 1 *** Unit: TAB Route: ORAL Schedule: Every four to six hours as needed. Dispense: *** 21 ***.
NOTES

INSTRUCTION (Thu Mar 09, 2017 10:34 BEN)

DISCHARGE: FRACTURED NOSE.
FOLLOWUP: None. Patient has, no PCP– See referral, Clinics, PHYSICIAN REFERRAL TO, UT ERLANGER PHYSICIANS GROUP, 423–778–DOCS (3627), Call UT Erlanger Physicians Group Referral line to help locate a physician., Urologists, Academic, UT. Clinics / Erlanger Practice, at Erlanger, Suite C–925, 979 East Third Street, Chattanooga TN 37311, 423–778–5910, Follow up with Specialist Call the office and make an appointment.
SPECIAL: (20) Follow up with Urology within 2 weeks.

Key:
AHUN=Hunzelman, RN, Ashley L BEN=Smith, MD, Benjamin LVAR=Varner, CPH T, Lee SEAR=Armstrong, RN, Sarah J

ACCT: 000120246350
03-09-17 08:17 CT THORAX ABD PELVIS W IV CONT

Erlanger Health System
975 East Third Street
Chattanooga, TN 37403
(423) 778-7241

NAME: KOGER,PHILLIP, MRN: 01171273

ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: CHEST, ABD TRAUMA
ORDER COMMENTS: BEH-ED 08
ECT CT THORAX ABD PELVIS W IV CONT - 03/09/2017 08:50 AM - CPT: 71260, 74177, 74177
COMPARISON: None.
HISTORY: Motor vehicle accident.
TECHNIQUE: Multidetector helical CT acquisition through the chest, abdomen, and pelvis is provided after IV administration of 100 mL of Omnipaque 300. Coronal and sagittal multiplanar reformatted images are provided. Automated dose control was used for these exams.
FINDINGS:
Chest:
There is mild dependent atelectasis at the bilateral lung bases. No suspicious pulmonary nodules or masses are seen. There is no evidence of pneumothorax. The heart size is within normal limits. No pericardial effusion. There is mild stranding within the anterior mediastinum without discrete hematoma. A focal area of gas is seen along the left half of the sternomanubrial joint. No underlying fracture is seen. No definite rib fractures are seen. The thoracic aorta is normal in caliber. The extra thoracic soft tissues are within normal limits. Normal attenuation of the imaged thyroid gland.
Abdomen/Pelvis:
Normal appearance of the liver. No focal hepatic mass. There is no evidence of laceration. No perihepatic free fluid. Normal appearance of the gallbladder. Normal appearance of the spleen. No evidence of active extravasation or laceration. Normal appearance of the kidneys. The adrenal glands are normal without mass or nodularity. Normal appearance of the pancreas.
The stomach and duodenum appear normal. The small and large bowel are normal in caliber. No focal wall thickening or dilatation. No free fluid. No drainable fluid collections. Normal CT appearance of the prostate gland and seminal vesicles. Normal appearance of the bladder. There is asymmetric enlargement of the left psoas muscle with adjacent stranding. No evidence of active extravasation.
Fractures are present through the left L1-L4 transverse processes. No pelvic fractures are identified. The SI joints and pubic symphysis are intact. The vertebral body heights are well-maintained. Schmorl's nodes are present along the inferior endplates of the lower thoracic vertebral bodies. A Schmorl's node is seen along the superior endplate of an upper thoracic vertebral body. There is no evidence of vertebral body fracture. The posterior elements are within normal limits.
IMPRESSION: There is mild stranding within the anterior mediastinal fat which could represent contusion without hematoma. A small amount of gas adjacent to the sternomanubrial joint may also be associated with blunt trauma without acute fracture.
Fractures through the left L1-L4 transverse processes with asymmetric enlargement of the left psoas muscle. No active extravasation.
DICTATED BY: HARRIS HAWK, MD - 03/09/2017 09:06 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD - 03/09/2017 09:15 AM
TRANSCRIBED BY: - PSC - 03/09/2017 09:15 AM
CC: EMCARE, PHYSICIAN

ACCT: 000120246350
03-09-17 08:17 HIP UNI 2-3 VWS

Erlanger Health System
975 East Third Street
Chattanooga, TN 37403
(423) 778-7241

NAME: KOGER,PHILLIP, MRN: 01171273

ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMA, PAIN
ORDER COMMENTS: BEH-ED 08
E/R HIP UNI 2-3 VWS L - 03/09/2017 08:43 AM - CPT: 73502
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well-maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well-maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD - 03/09/2017 03:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD - 03/09/2017 08:56 AM
TRANSCRIBED BY: - PSC - 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN

ACCT: 000120246350
03-09-17 08:17 KNEE 3 VIEWS

Erlanger Health System
975 East Third Street
Chattanooga, TN 37403
(423) 778-7241

NAME: KOGER,PHILLIP, MRN: 01171273

ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMA, PAIN
ORDER COMMENTS: BEH-ED 08
E/R KNEE 3 VIEWS L - 03/09/2017 08:44 AM - CPT: 73562
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well-maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well-maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD - 03/09/2017 08:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD - 03/09/2017 08:56 AM
TRANSCRIBED BY: - PSC - 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN

ACCT: 000120246350
03-09-17 08:29 CHEST SINGLE VIEW

Erlanger Health System
975 East Third Street
Chattanooga, TN 37403
(423) 778-7241

NAME: KOGER,PHILLIP, MRN: 01171273

ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMATIC INJURY
ORDER COMMENTS: BEH-ED 08
E/R CHEST SINGLE VIEW - 03/09/2017 08:44 AM - CPT: 71010
HISTORY: TRAUMATIC INJURY.
COMPARISON: None.
TECHNIQUE: Single AP view the chest
RESULTS:
The heart size is normal in appearance. The pulmonary vasculature is mildly congested which is likely related to supine technique. There is no evidence of pneumothorax. No mediastinal shift. No displaced rib fractures are seen. No subcutaneous emphysema. The trachea is midline.
IMPRESSION: Pulmonary venous congestion at least in part due to supine technique. No pneumothorax is seen.
DICTATED BY: HARRIS HAWK, MD - 03/09/2017 03:58 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD - 03/09/2017 09:00 AM
TRANSCRIBED BY: - PSC - 03/09/2017 09:00 AM
CC: EMCARE, PHYSICIAN

ACCT: 000120246350
03-09-17 08:29 PELVIS 1 OR 2 VIEWS

Erlanger Health System
975 East Third Street
Chattanooga, TN 37403
(423) 778-7241

NAME: KOGER,PHILLIP, MRN: 01171273

ADMIT DIAGNOSIS: FACIAL FX
ORDER REASON: TRAUMATIC INJURY
ORDER COMMENTS: BEH-ED 08
E/R PELVIS 1 OR 2 VIEWS - 03/09/2017 08:46 AM - CPT: 72170
HISTORY: TRAUMA, PAIN.
COMPARISON: None.
TECHNIQUE: AP view of the pelvis, 2 views of the left hip, 3 views of the left knee.
RESULTS:
Pelvis: The bone mineralization is within normal limits. There is no evidence of acute fracture or dislocation. The joint spaces are well-maintained. No significant soft tissue abnormality.
Left hip: The left hip is well articulated. There is no evidence of acute fracture or dislocation. The bone mineralization is normal. Normal appearance of the femoral head neck junction.
Left knee: The medial and lateral compartment joint spaces are well-maintained. There is no evidence of acute fracture or dislocation. There is no evidence of joint effusion. No significant soft tissue abnormality.
IMPRESSION: Pelvis: No evidence of acute fracture or dislocation.
Left hip: No evidence of acute fracture or dislocation.
Left knee: No evidence of acute fracture or dislocation.
DICTATED BY: HARRIS HAWK, MD - 03/09/2017 08:54 AM
ELECTRONICALLY SIGNED BY: HARRIS HAWK, MD - 03/09/2017 08:56 AM
TRANSCRIBED BY: - PSC - 03/09/2017 08:56 AM
CC: EMCARE, PHYSICIAN

I-STAT G3+

Pt:000120246350
Pt Name: Koger

37.0°C

pH	7.442
PCO2	34.9 mmHg
PO2	84 mmHg
BEecf	0 mmol/L
HCO3	23.8 mmol/L
TCO2	25 mmol/L
sO2	97 %

Field 1: 3
Field 2: 56
Field 3: .
FIO2: 21

08:29 09MAR17

Operator ID: 6666
Physician:

Lot Number: 212D163221240
Serial: 387328
Version: JAMS142E
CLEW: A33
Custom: 17308325

I-STAT CHEM8+

Pt:000120246350
Pt Name:

Na	139 mmol/L
K	4.8 mmol/L
Cl	104 mmol/L
iCa	1.10 mmol/L
TCO2	23 mmol/L
Glu	127 mg/dL
BUN	19 mg/dL
Crea	1.2 mg/dL
Hct	54 %PCV
AnGap	18 mmol/L

Field 1: 3
Field 2: 56
Field 3: .
CPB: No

08:29 09MAR17

Operator ID: 6666
Physician:

Lot Number: 229H163511181
Serial: 334519
Version: JAMS142E
CLEW: A33
Custom: 17308325

03/15/2017
01:00

ERLANGER HEALTH SYSTEM
BARONESS ERLANGER LABORATORY
CHATTANOOGA,TENNESSEE 37403
MEDICAL DIRECTOR, JOYCE D MILLS M.D.

NAME: KOGER,PHILLIP WAYNE
AGE: 32Y SEX: M DOB: 1984
LOC: BEER
DR.: SMITH,BENJAMIN C III MD

ADMITTED: 03/09/2017
MR#: 1171273
ACCT: 000120246350
DISCHARGED: 03/12/2017

BLOOD GASES

		NORMAL	UNITS
DATE:	03/09/17		
TIME:	0829		
LOC:	BEER		
FOOTNOTE:	#1		
PH	7.44	7.35-7.45	
PaCO2	35	35-45	MMHG
PaO2	84	80-100	MMHG
HCO3	24	22-28	MEQ/L
BASE EXCESS	0		MEQ/L
O2 SATURATION	97	95-100	%
FI02	21		%
SAMPLE SITE	LFM		
VENT SETTINGS			

#1 SAMPLE SITE = LEFT FEMORAL
VENT SETTINGS = if critical values see chart for notification

MISCELLANEOUS ISTAT TESTS

		NORMAL	UNITS
DATE:	03/09/17		
TIME:	0829		
LOC:	BEER		
SODIUM	139	135-153	MMOL/L
POTASSIUM	4.8	3.5-5.3	MMOL/L
CHLORIDE	104	97-107	MMOL/L
BUN	19	9-21	MG/DL
CREAT	1.2	0.8-1.5	MG/DL
GLUCOSE	127 H	70-105	MG/DL
IONIZED CA	1.10 L	1.12-1.32	MMOL/L
CO2	23	23-27	MMOL/L
HCT	54 H	42-52	%

END OF REPORT